ONTARIO BIOLOGICS RESEARCH INITIATIVE: SAFETY AND EFFECTIVNESS

PHYSICIAN PROCEDURE MANUAL

TABLE OF CONTENTS

Table of Study Documents (CRFs) – Quick Reference Guide

Study Document (CRF)	Study Phase
Office Consent Form*	Screening (faxed from site to OBRI)
Patient Information Package	Screening (site provides to patient)
Daily Fax Sheet*	Screening (site faxes to OBRI)
Biologic Tracking Log	Screening (site faxes to OBRI)
Enrolment Notification Form	Enrollment (site faxes to OBRI)
Study Assessment Form	Baseline Follow-up (site faxes to OBRI)
Concurrent Anti-Rheumatic Medications Form	Baseline Follow-up (site faxes to OBRI)
Withdrawal Notification Form	Early Withdrawal (site faxes to OBRI)

* Sites that do not have Research Ethics Board permission to fax this information to OBRI will communicate the information contained on these documents/CRFs by telephone or mail.

UHN Data Management Centre:
Ontario Biologics Research Initiative: Safety and Effectiveness
200 Elizabeth St. 13 EN-224
Toronto, On M5G 2C4
Tel: (866) 213-5463
Fax: (888) 757-6506
Email: obri@uhnres.utoronto.ca

1.Background

The Ontario Biologics Research Initiative (OBRI) has been developed by a range of stakeholders including patients, rheumatologists and researchers. The goals of the OBRI are to determine the long term effectiveness and safety of biologic response modifying drugs (BRMs) for inflammatory arthritis in usual practice and to develop and evaluate a range of strategies to facilitate best practice implementation and post-marketing surveillance of all disease modifying drugs in real-world rheumatology care.

2. Purpose

This prospective controlled study will compare the real-world effectiveness of BRMs to older Disease Modifying Anti-Rheumatic Drugs (DMARDs) in adults with rheumatoid arthritis (RA) who reside in Ontario. This study will also develop analytic tools to facilitate low-cost, real-world surveillance through administrative database linkages in combination with minimal clinical data collection. These tools will allow us to improve the utility of using administrative databases to identify serious adverse events (SAEs) and monitor health service utilization in patients receiving BRMs and other new drugs.

3. Study Design

Rheumatologists (also described as Investigators) will be recruited through the Ontario Rheumatology Association (ORA) and the Canadian Rheumatology Research Consortium (CRRC) as well as other peer networks that have supported the development of this study. Approximately 40 rheumatology sites from across Ontario will participate by enrolling subjects on DMARD or BRM treatment. The screening and enrollment of subjects will take approximately one year and subjects will be followed for a total duration of five years or until the subject withdraws from the study.

4. Study Documentation

4.1 Investigator Study Binder

Each participating site will maintain and keep a current Investigator Study Binder which will document all activities associated with conducting and preserving the study to its entirety. The binder will include:

- OBRI Contact Information (Study Personnel, Local OBRI Investigators, Site Signature and Delegation Log)
- Protocol
- Procedure Manual
- Case Report Forms
- REB Approvals and Renewals
- Clinical Study Agreement and Budget
- Study Correspondence (Reports/Queries)
- Appendices

5. Study Procedures

5.1 Flowchart

Patient has active RA and is currently on a BRM and/or DMARD

Investigator informs patient about OBRI

Patient Declines

Patient Agrees

Patient signs *Consent Form to Release my Personal Information for Study Purposes* and Site gives patient the *Patient Information Package*

***Daily Fax Sheet* faxed from site to OBRI**

Patient is contacted by OBRI Interviewer. OBRI sends site weekly reports indicating patient's consent status (i.e., agreed, refused, or pending)

Patient Declines

Patient Agrees

Site faxes *Enrollment Form, Baseline Study Assessment Form, and Medication Form* to OBRI

Site faxes New *Study Assessment Form* and updated *Medication Form* to OBRI after every follow up visit

Patient withdraws from study and site faxes Withdrawal Notification Form to OBRI

Site faxes New *Study Assessment Form* and updated *Medication Form* to OBRI after every follow up visit for 5 years

5.2 Case Report Form (CRF) Completion

All CRFs are to be filled out with a black or blue ballpoint pen and must be legible. Corrections to CRFs will be made by a single line stroke through the error and insertion of the correction above or beside the error. The change must be initialed and dated by the investigator and/or their designee. No erasures, correction fluid, or tape may be used. All written information and other material must use vocabulary and language that are clearly understood. All CRF entries must be in English.

All required information on the CRF must contain an entry. If a specific evaluation or measure was not completed at the visit, **"Not Done"** should be recorded in that field.

NOTE: The site will be queried for any missing information or entries left blank.

5.3 Screening and Consent Process

5.3.1 Consent Form to Release my Personal Information for Study Purposes

The consent process for the OBRI study is two tiered. Before the site can send personal patient information to the OBRI Data Management Centre (DMC), they will need the patient to sign the Consent Form to Release my Personal Information for Study Purposes. OBRI will supply these forms to the site.

The study specific Informed Consent form will be provided to the patient as part of the Patient Information Package (described below in 5.3.2), and an OBRI interviewer will call the patient to review the study specific Informed Consent Form and answer any questions the patient may have regarding the study.

NOTE: The site is not responsible for having the patient complete the study specific Informed Consent Form. This is the interviewer's responsibility and should not be undertaken by the site.

NOTE: It is very important that the site provide each patient with the Patient Information Package. The interviewer expects to review this information with the patient at first contact. If the patient does not have a Patient Information Package when the interviewer reaches them, the consent process will be delayed until the patient receives a package by mail.

5.3.2 Patient Information Package

The Data Management Centre will provide each site with Patient Information Packages. These packages will contain a site specific copy of the Patient Information Brochure, Consumer Brochure, OBRI Informed Consent Form(s), and an OBRI self addressed stamped envelop. Each patient who signs the Consent Form to Release my Personal Information for Study Purposes should be given a Patient Information Package before leaving the rheumatologist's office.

5.3.3 Daily Fax Sheet

After the patient has signed the Consent Form to Release my Personal Information for Study Purposes, and has been given a Patient Information Package, the site will record the patient's ID#, name, telephone number(s), and the date the patient agreed to be contacted on the Daily Fax Sheet. The Daily Fax Sheet is then faxed to the OBRI Data Management Centre.

For instructions on completion of the Daily Fax Sheet refer to *Appendix 1*.

5.3.4 Biologic Tracking Log

The Biologic Tracking Log should be faxed to the OBRI Data Management Centre every month. It is used to track the number of patients being prescribed a new biologic

For instructions on completion of the Biologic Tracking Log refer to *Appendix 2.*

5.4 Enrollment

5.4.1 OBRI Site Summary Report of Patient Status

` Each week, sites will receive a report indicating the status of the patients they have referred to OBRI (*Appendix 3*). This report lists those patients who have consented, and those who have refused to participate in OBRI, as indicated by the OBRI interviewers. For sites who recruited patients to the OBRI study prior to August of 2011, a list of patients who have consent or refused to re-consent to the 5 year follow up will also be provided.

5.4.2 OBRI Patients with Consent Pending Report

Each week, sites will also receive a report which lists Patient ID#s for those patients who have not yet agreed or refused to participate in the OBRI study (*Appendix 4*). Patients with consent pending refers to those patients the interviewers have either not been able to reach or patients who have scheduled a future time for the interviewer to call back to discuss the study.

5.4.3 Enrollment Notification Form

After the site has been notified of a patient's consent to participate in the OBRI study, they should complete the Enrollment Notification Form and fax to the OBRI Data Management Centre.

The Enrollment Notification Form is completed once for each patient.

For instructions on completion of the Enrollment Notification Form refer to *Appendix 5*.

5.4.4 Study Assessment Form

The Baseline Study Assessment Form should be completed once the site has been notified of a patient's consent to participate in the OBRI study. This form should be faxed to the OBRI Data Management Centre.

For instructions on completion of the Study Assessment Form refer to *Appendix 6*.

5.4.5 Current Anti-Rheumatic Medication Form

The Current Anti-Rheumatic Medication Form should be completed, for the first time, after the site has received confirmation of the patient's consent to participate in the OBRI study.

For instructions on completion of the Current Anti-Rheumatic Medication Form refer to *Appendix 7.*

5.5 Follow-up

5.5.1 Study Assessment Form

A new Study Assessment Form should be completed approximately every 6 months, or sooner if changes are being made to the patient's RA medications.

For instructions on completion of the Study Assessment Form refer to *Appendix 6.*

5.5.2 Current Anti-Rheumatic Medication Form

The Current Anti-Rheumatic Medication Form should be updated at each patient visit.

For instructions on completion of the Current Anti-Rheumatic Medication Form refer to *Appendix 7.*

5.5.3 Withdrawal Notification Form

A Withdrawal Notification Form should be completed by the site, if during a patient visit, the patient decides they no longer wish to participate in the OBRI study. This form should be faxed to the OBRI data Management Centre immediately.

For instructions on completion of the Withdrawal Notification Form refer to *Appendix 8.*

5.5.4 Enrollment Query Form

All evaluations or information requested on the Enrollment Notification Form are expected to be completed by the site. If a particular evaluation was not completed or specific information is not available, the site should enter **NOT DONE**. Any missing evaluations or information on the Enrollment Notification Form will be queried.

For instructions on responding to the Enrollment Query Form refer to *Appendix 9.*

5.5.5 Assessment and Medication Query Form

All evaluations or information requested on the Study Assessment and Concurrent Anti-Rheumatic Medication Forms are expected to be completed by the site. If a particular evaluation was not completed or specific information is not available, the site should enter **NOT DONE.** Any missing evaluations or information on the Study Assessment and Concurrent Anti-Rheumatic Medication Forms will be queried.

For instructions on responding to the Assessment and Medication Query Form refer to *Appendix 10.*

Appendix 1: Daily Fax Sheet

PLEASE FAX THIS SHEET DAILY TO:
OBRI

Fax: 416-340-5968 or 1-888-757-6506

Investigator:	1	Site #:	2
Tel./Fax:	Phone: ( ) Fax: ( ) 3		
Sender:	4	Date:	5

Please print the name, area code and telephone number(s) and date subject agreed to be contacted by OBRI.

	Name (First, Middle Initial, Last)	Telephone Number	Date
1xx001		Day: ( ) Eve: ( )	
1 6 2	7	Day: ( ) 8 Eve: ( )	9
1xx003		Day: ( ) Eve: ( )	
1xx004		Day: ( ) Eve: ( )	
1xx005		Day: ( ) Eve: ( )	
1xx006		Day: ( ) Eve: ( )	
1xx007		Day: ( ) Eve: ( )	
1xx008		Day: ( ) Eve: ( )	
1xx009		Day: ( ) Eve: ( )	
1xx010		Day: ( ) Eve: ( )	

Daily Fax Sheet

1. Investigator
The Investigator's name will be pre printed for each site.

2. Site
The site number (i.e., 3 digit number beginning with the number 1) will be pre printed for each site.

3. Tel/Fax
The Investigator's telephone and fax numbers will be pre printed for each site.

4. Sender
The name of the person completing this form should be provided here.

5. Date
Whenever a new Daily Fax Sheet Form is needed, the current date should be entered (i.e., each Daily Fax Sheet has space for ten new patients).

6. ID#
Patient ID#s are made up of six digits. The fist 3 numbers of the Patient ID# represents the site number. The site number will always begin with the number 1. The last 3 digits of the Patient ID#s are assigned sequentially at each site (i.e., 001, 002, 003…). Only **ONE** patient name should be entered per line.

7. Name
Both first and last names are required. If the patient's name is ambiguous, please use a suffix before their name (i.e., Mr/Mrs/Ms).

8. Telephone
Provide the patient's home telephone number or cell number (if this is their primary number), and/or an alternate if available.

9. Date
Insert the date the patient was seen by their rheumatologist.

NOTE: Patient ID#s should **NEVER** be reused (for example, if a patient refuses to participate in the OBRI study, their ID# should not be assigned to a new patient in the future.

NOTE: The site is responsible to ensure that the phone numbers they are providing for the patient are the most recent and that the patient is aware that an OBRI interviewer will be trying to reach them at this number. Any wrong phone numbers or disconnected phone numbers will result in a delay in obtaining consent.

Appendix 2: Biologic Tracking Log

Site Number: _1_____ Month of: _____2_____ Year: 20___3

BIOLOGIC TRACKING LOG

Day of Month	Number of Patients Prescribed * a New Biologic**	Day of Month	Number of Patients Prescribed* a New Biologic**
1	4	16	
2		17	
3		18	
4		19	
5		20	
6		21	
7		22	
8		23	
9		24	
10		25	
11		26	
12		27	
13		28	
14		29	
15		30	
		31	

*includes patients starting their first biologic and patients who may have previously been on a biologic who are switching biologics.
** Count prescriptions even if approval is pending
Please strike through dates that no patient contact was made (e.g. weekends, non-clinic days)

Rheumatologist Name:___5_____

Biologic Tracking Log

1. Site Number
Provide the 3 digit site number, which always begins with the number 1.

2. Month of
Record the month corresponding to the data that will be entered on to the form.

3. Year
Record the year corresponding to the data that will be entered on to the form.

4. Number of Patients Prescribed a New Biologic
For each day of the month, provide the number of patients who were seen in the clinic and prescribed a new biologic on that day.

5. Rheumatologist Name
Record the Rheumatologist's Name.

Appendix 3: OBRI Site Summary Report of Patient Status

OBRI
Site Summary Report of Patient Status
For the Period from 22-Oct-10 to 14-Dec-10

Site Number: ***Rheumatologist's Name:*** Dr.
Consent Version: 11.1

Consented

Patient ID	*Referred*	*Date Consented*
	15-Nov-10	26-Nov-10
	20-Oct-10	31-Oct-10
	01-Nov-10	16-Nov-10
	03-Nov-10	19-Nov-10
	12-May-10	26-Oct-10

Total Patients Consented for the period: 5

Refused

Patient ID	*Referred*	*Date Refused*	*Reason for Refusal*
	22-Sep-10	16-Nov-10	No specific (or other) reason given
	22-Sep-10	16-Nov-10	No specific (or other) reason given
	13-Oct-10	28-Nov-10	Language barrier
	01-Nov-10	04-Dec-10	Unable to reach (after allotted number of calls)

Total Patients Refused for the period: 4

Re-Consented from 2 year to 5 year Follow-Up

Patient ID	*Referred*	*Date Re-Consented from 2 year to 5 year Follo*
	07-May-08	07-Dec-10
	26-May-08	09-Dec-10
	03-Nov-08	27-Nov-10

Total Patients Re-Consented from 2 year to 5 year Follow-Up for the period: 3

Refused to Re-Consent from 2 year to 5 year Follow-Up

Patient ID	*Referred*	*Date Refused to Re-Consent from 2 year to 5 ye*
	14-May-08	24-Nov-10
	14-Jul-08	24-Nov-10

Total Patients Refused to Re-Consent from 2 year to 5 year Follow-Up for the period: 2

Patients referred to OBRI to date: 57

Report Generated: 12/14/2010 3:25:25 PM *Page 1 of 1*

Appendix 4: OBRI Patients with Consent Pending

OBRI Patients with Consent Pending for Site:
Dr.

Patient	Consented to be contacted	Last Call Attempt	Last Call Result
	18-Oct-10	12/07/2010 10:13:41 AM	unable to reach
	08-Dec-10	02/02/2011 8:24:26 PM	rescheduled interview (not started)
	15-Jan-11	01/26/2011 7:08:42 PM	interview booked
	13-Jan-11	02/07/2011 4:10:54 PM	voice mail
	17-Jan-11	02/02/2011 7:55:58 PM	interview booked
	20-Jan-11	02/07/2011 4:30:02 PM	delay/postpone interview

Report Generated on 02/07/2011 4:31:50 PM *Page 1 of 1*

Appendix 5: Enrollment Notification Form

Ontario Biologics Research Initiative: Safety and Effectiveness Study

University Health Network

1 Site: __ __ __ Patient Number: __ __ __ Patient Initials: __ __ __

2 **ENROLLMENT NOTIFICATION FORM**

Date of Baseline Assessment: _____/_____/_____(dd/mm/yyyy)

3 **PATIENT INFORMATION**

Name: _____ **Gender:** ☐ **Male** ☐ **Female**

Address:_____ **City:** _____ **Prov: ON** **PC:**_____

Telephone: _____ **DOB:** ____/____/_____ **Health Card Number:** _____/_____/_____ **v**____
(dd/mm/yyyy)

►**Refer to The Arthritis Society Arthritis Rehabilitation & Education (AREP) Program:** ☐ No ☐ Yes

4 **RHEUMATOID ARTHRITIS HISTORY**

►**Rheumatologist Diagnosis of RA:** ☐ Yes ☐ No ►**Date of Diagnosis:** ☐ Year _____ ***or*** ☐ Age _____

►**Active RA** (≥1 swollen joint) ☐ Yes ☐ No ☐ Unknown

►**Rheumatoid Factor:** ☐ Positive ►**Anti-CCP:** ☐ Positive
☐ Negative ☐ Negative
☐ Unknown ☐ Unknown

►**Extra-Articular Features**: ☐ Absent ☐ Nodules ☐ Interstitial Lung Disease ☐ Ocular ☐ Neurologic
☐ Felty's ☐ Vasculitis ☐ Sjogren's ☐ Unknown ☐ Other:_____

5 **RA MEDICATION HISTORY and TREATMENT CHANGES BEING MADE TODAY**

►**Has patient ever had DMARD therapy?** ☐ No ☐ Yes ☐ Unknown

►**Has patient ever had biologic therapy?** ☐ No ☐ Yes ☐ Unknown (i.e., RCT) ☐ Indication other than RA

Previous Biologics	Start Date mm/yy	Stop Date+ mm/yy	Discontinuation Code++
1st Biologic:			
2nd Biologic:			
3rd Biologic:			
4th Biologic:			

++Discontinuation Code:
1. Primary Failure (Never achieved response)
2. Secondary Failure (Failure to maintain response after ≥ 3 months
3. Adverse Event
4. Patient Choice 5. Funding
6. Other

+For infusions, record stop date as date of last infusion.

6 ► **Are medications being prescribed/changed TODAY?:** ☐ No ☐ Yes.

If yes, answer the following questions:

7 ► **Is the patient discontinuing any rheumatic drug(s) today?**
☐ No ☐ Yes ➡ Name:_____ Discontinuation Code:_____
Name:_____ Discontinuation Code:_____

8 ►**Is the patient being prescribed NEW traditional DMARD(s) today?**
☐ No ☐ Yes ➡ DMARD Name(s):_____ & _____

9 ►**Is the patient changing the dose or route of administration of ongoing Biologic or DMARD today?**
☐ No ☐ Yes ➡ Name:_____ ☐ Change of Route ➡ From ____ to ____
Name:_____ ☐ Change of Dose ➡ From ____ to ____

10 ►**Is the patient being prescribed a NEW biologic drug today?**
☐ No ☐ Yes ➡ Biologic Name:_____

11 ►**If so, were Funding Support Forms Submitted:**
☐ No ☐ Yes ➡ Date forms submitted: ☐ **Today OR:** ____/____/_____(dd/mm/yyyy) ☐ Unknown

12 **Signature:** _____ **Date:** _____ (dd/mm/yyyy)

PLEASE FAX FORM TO:
1-888-757-6506

Enrollment Notification Form Page 1 of 1 Version 11 March 31 2010

After the site has received confirmation of the patient's consent to participate in the OBRI study, they are to fax the Enrollment Notification Form to the site as soon as possible.

Enrollment Notification Form

1. Enrollment Information
Enter the 3 digit site number, 3 digit patient number and patient initials (first, middle, last names).

2. Date of Assessment
Enter the date of the Baseline Assessment as dd/mm/yyyy.

3. Patient Information
Personal information including the patient's name, address, gender, DOB and health card number must be recorded in order to obtain demographic variables and to facilitate the linkage to administrative data held at the Institute of Clinical Evaluative Sciences (ICES).

4. Rheumatoid Arthritis History
The section on Rheumatoid Arthritis History refers to the patient's previous medical history as it relates to their diagnosis of RA. Make sure to complete all headings and if any information is unknown or not available, check (√) the appropriate box or enter "Not Done".

5. RA Medication History
Indicate whether or not the patient has had previous Biologic or DMARD therapy. If the patient has previously used a biologic, record the name(s) of the biologics in the table provided, as well as the start date, stop date and reason for discontinuation.

6. RA Medications Prescribed/Changed Today
Indicate whether or not new medications or a change in current medications (i.e., dose, route) will be made at this baseline visit.

7. Discontinuing Rheumatic Drugs Today
Indicate whether or not the patient will be discontinuing any rheumatic drug(s) today, and if yes, the name of the drug and the reason for discontinuation

8. Prescribing New DMARDs Today
Indicate whether or not the patient will be receiving a prescription for an NEW DMARD, and if yes, the name of the DMARD being prescribed.

9. Changing Dose or Rout of ongoing Biologic or DMARD Today
Indicate whether or not the patient will be changing the dose or route of administration of an ongoing biologic or DMARD at this visit. If yes, record the name(s) of the drug and specify whether the route, or dose is being changed, and the change being made (e.g., from 5mg to 10 mg)

10. Prescribing a New Biologic Today
Indicate whether or not the patient is being prescribed a new biologic at this visit. If yes, record the name of the biologic.

11. Funding Support Forms
If the patient is being prescribed a new biologic at this visit, indicate whether or not Funding Support Forms were submitted and the date of this submission.

12. Signature and Date
Please ensure the form is signed and dated by the person completing the form. The form should be faxed to the data management centre at the number provided, within 7 days from receipt of the confirmation fax.

Appendix 6: Study Assessment Form

Ontario Biologics Research Initiative: Safety and Effectiveness Study

Site: __ __ __ Patient Number: __ __ __ Patient Initials: __ __ __

University Health Network

STUDY ASSESSMENT FORM
PLEASE FAX TO: 1-888-757-6506

1

2 **Visit Information:**

Date: __/___/___(dd/mm/yyyy)
☐ Baseline ☐ Follow-up

3 **Form Completed By:**

Signature:_____
Date:__/__/___ (dd/mm/yyyy)

8 **Laboratory:**

ESR: __ __ __ mm/hr ☐ Not Done **CRP:** __ __ __ . __ mg/l ☐ Not Done
Date: __/___/___(dd/mm/yy) **Date:**___/___/___ (dd/mm/yy)

4 **Physician Global Assessment of Current Disease Activity:**

How active is the rheumatoid arthritis **TODAY**?

Not Active											Extremely
At All	0	1	2	3	4	5	6	7	8	9	10 Active

5 **Patient Global Assessment of Current Disease Activity:**

How active has the rheumatoid arthritis been in the **LAST 24 HOURS?**

Not Active											Extremely
At All	0	1	2	3	4	5	6	7	8	9	10 Active

6 **Co-Morbidities & Serious Events:**

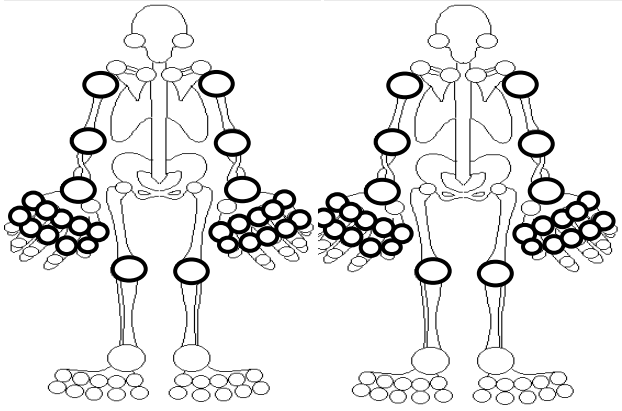
☐ **NO CHANGE at Follow-up**
☐ **Depression:**_____
☐ **Cardiovascular:** ☐ Coronary Artery Disease ☐ CHF ☐ HTN ☐ Arrhythmia ☐ Other:_____
☐ **CNS:** ☐ Stroke ☐ TIA ☐ Other: _____
☐ **Lung Disease:** ☐ Asthma ☐ COPD ☐ Pulmonary Embolism ☐ ILD ☐ Other:_____
☐ **GI:** ☐ Ulcer ☐Other:_____
☐ **Kidney Disease:**_____
☐ **Diabetes:** ☐ Type I ☐ Type II
☐ **Hematologic:** ☐ Anemia ☐ Other:_____
☐ **Liver Disease:**_____
☐ **Osteo or Degenerative Arthritis:**_____
☐ **Autoimmune Disease:** ☐ SLE ☐ Vasculitis ☐ Other:_____
☐ **Cancer:**_____
☐ **Serious Infection:**_____
☐ **Tuberculosis:**_____
☐ **Fungal Infection:**_____
☐ **Central Demyelination:**_____
☐ **Other:** _____

7 ► **Did any of these events result in death/hospitalization/IV antibiotics/significant loss of function or disability/congenital malformation/or was life threatening?**
☐ **No** ☐ **Yes, Specify:**_____

9 **Joint Assessment:**

We have provided a 68 joint homunculus. However, we only require a **28 joint count assessment** (selected joints are highlighted). Please shade in all tender & swollen joints. If a joint has been replaced or injected with corticosteroids within the last 3 months, it should NOT be counted. Please use an **arrow** to indicate these joints.

Tender Joint Count	Swollen Joint Count



Number of Tender Joints: _____ **Number of Swollen Joints:** _____

10 ► **Erosions on X-ray?** ☐ **No** ☐ **Unsure** ☐ **Yes, Year of X- Ray:**___

11 **Additional Comments:**

Study Assessment Form

1. Patient Information
Provide Site Number, Patient Number and Patient Initials

2. Visit Information
Provide the date of assessment. Check (√) either baseline or follow-up visit.

3. Form Completed By
Please ensure the form is signed and dated by the person who is completing the form.

4. Physician Global Assessment
Complete by assigning a numerical value corresponding to your opinion of the patient's RA disease activity today, 0 is Not Active at ALL and 10 is Extremely Active.

5. Patient Global Assessment
Complete by asking the patient how active their rheumatic arthritis has been in the lat 24 hours on a scale of 0 to 10. 0 is Not Active at All and 10 is Extremely Active.

6. Co-Morbidities and Serious Events
Select all co-morbidities associated with the patient's medical history. If an indication is selected, please specify the disease in more detail (i.e., if cancer is selected, specify type).

At follow-up visits, if there is NO CHANGE to co-morbidities, please check (√) the corresponding box, otherwise a co-morbid condition must be selected.

7. Did any of these events result in death/hospitalization/IV antibiotics/significant loss of function or disability/congenital malformation/ or was life threatening.
If a co-morbidity has been selected in #6, either the yes or no box needs to be checked in this section.

8. Laboratory
Complete by transcribing the most recent ESR (mm/hr) and CRP (mg/l) values along with dates these laboratory results were obtained. If NOT DONE, indicate by checking (√) the corresponding box. ESR and/or CRP values are required to properly calculate the DAS28.

9. Joint Assessment
Two homunculi are present, one for a 28 tender joint count and one for a 28 swollen joint count. Indicate which joint(s) are tender and/or swollen by shading in the affect areas. IF a joint has been replaced, undergone surgery or recently injected within the last 3 months, it should not be counted and an arrow (→) should be used to illustrate those joint(s). Complete the joint assessment by writing the numerical value in the box below.

10. Comments
Please feel free to record any comments or additional information.

NOTE: When completing a baseline Study Assessment Form make sure that the assessment date on this form matches the baseline date noted in the Enrollment Notification Form.

Appendix 7: Concurrent Anti-Rheumatic Medications Form

Ontario Biologics Research Initiative: Safety and Effectiveness Study

University Health Network
Toronto General Hospital Toronto Western Hospital Princess Margaret Hospital

1 **Site: __ __ __ Patient Number: __ __ __ Patient Initials: __ __ __**

CONCURRENT ANTI-RHEUMATIC MEDICATIONS *(For Dosage changes, record as new entry)*

Medication Name	Dose 3				Start Date (dd/mm/yyyy)	Stop Date (dd/mm/yyyy)	Visit Date ___/___/____ (dd/mm/yyyy)	Visit Date ___/___/____ (dd/mm/yyyy)	Visit Date ___/___/____ (dd/mm/yyyy)	Visit Date ___/___/____ (dd/mm/yyyy)
	Qty	Units	Freq	Route	4	5	*Please initial after reviewing / updating at each assessment*			
				po sc other	___/___/____	___/___/____ 1° Failure AE 2° Failure Oth*__				
				po sc other	___/___/____	___/___/____ 1° Failure AE 2° Failure Oth*__				
				po sc other	___/___/____	___/___/____ 1° Failure AE 2° Failure Oth*__	6			
				po sc other	___/___/____	___/___/____ 1° Failure AE 2° Failure Oth*__				
				po sc other	___/___/____	___/___/____ 1° Failure AE 2° Failure Oth*__				
				po sc other	___/___/____	___/___/____ 1° Failure AE 2° Failure Oth*__				
				po sc other	___/___/____	___/___/____ 1° Failure AE 2° Failure Oth*__				
				po sc other	___/___/____	___/___/____ 1° Failure AE 2° Failure Oth*__				
				po sc other	___/___/____	___/___/____ 1° Failure AE 2° Failure Oth*__				
				po sc other	___/___/____	___/___/____ 1° Failure AE 2° Failure Oth*__				

1° Failure = Never achieved response, **2° Failure** = Failure to maintain response after ≥ 3 months
***Other: 1** = Reimbursement Issues, **2** = Patient Decision, **3** = Physician Decision, **4** = Improvement, **5** = Completed Treatment, **6** = Dosage Change, **7** = Pregnancy, **8** = Other

COMMENTS:

2

Please Fax Completed Form to 1-888-757-6506 **Page __ of __** **Version 7 March 31, 2010**

Concurrent Anti-Rheumatic Medications Form

1. Patient Information
Insert Site Number, Patient Number and Patient Initials.

2. Medication Name
Record one drug name per line. If a change in route, dose, or frequency is being made to a concurrent medication, a new entry for this medication should be made, and a stop date provided for the entry with the previous route, dose or frequency (i.e., provide stop date for the discontinued dose or route).

3. Dose
Specify the quantity (i.e., 100), units (i.e., mg), and frequency (i.e., bid) of the prescribed medication and indicate the route through which the drug is administered.

4. Start Date
Record the date the prescribed medication was started (i.e., date of first dose). If the day and/or month are unknown, please use UK to indicate date is not known otherwise a query will be generated for missing data.

5. Stop Date
Record the date the prescribed medication was stopped (i.e., date of last dose).
Specify the reason for the drug discontinuation by choosing one of the following;
1° (Primary) Failure = Never achieved response
2° (Secondary) Failure = Failure to maintain response after ≥ 3 months
AE = Adverse Event
Other: 1 = Reimbursement Issues, 2 = Patient Decision, 3 = Physician Decision, 4 = Improvement, 5 = Completed Treatment, 6 = Dosage Change, 7 = Pregnancy, 8 = Other
A legend is provided at the bottom of the medication form.

6. Visit Date
At each visit, please insert the date of the assessment, and initial each row in this column which contains a medication name, to indicate that the status of the medication information in each row has been verified / updated at this visit.

7. Comments
Please feel free t o record any comments or additional information.

NOTE: Only RA medications should ne noted on this form. Please do not include any herbal, over the counter, or medications used for other disorders/diseases (heart condition, diabetes...).

NOTE: All parts of the medication form need to be completed, i.e., route, frequency and if a stop date is provided please enter the reason for stopping.

NOTE: When a frequency, dose or route change is made to a current medication, it should be re-entered as a new medication. In this case, make sure a STOP DATE (and a stop reason) has been entered for the previous frequency, dose or route.

NOTE: The Anti-Rheumatic Medication Form is a running list. DO NOT start a new medication form until all rows on the first medication form have been filled. When all medication rows on the first medication form have been entered and a second medication form is started, the first medication form still needs to be reviewed at each patient visit to make sure stop dates are not ignored for those medications that were previously listed and ongoing. When more than one medication form is required for a patient, be sure to fax OBRI all medication pages for that patient (not only the most recent).

Appendix 8: Withdrawal Notification Form

Ontario Biologics Research Initiative:
Safety and Effectiveness Study

University Health Network
Toronto General Hospital | Toronto Western Hospital | Princess Margaret Hospital

1 Site Number: __ __ __ Patient Number: __ __ __ Patient Initials: __ __ __

Withdrawal Notification Form

2 Date of Last Visit: ____/____/____ (dd/mm/yyyy)

3 **Reason for Early Withdrawal**

1. □ Withdrew consent, check all that apply;

   □ Withdrew consent to have **rheumatologist** provide personal health information to the Study Coordinator at the University Health Network
   □ Withdrew consent to be contacted by the **telephone interviewer** to complete study questionnaires
   □ Withdrew consent to have personal health information linked to health care databases stored at The **Institute for Clinical Evaluative Sciences (ICES)**
   □ Withdrew consent to be contacted about **future studies** related to this project
   □ Withdrew consent to be contacted, by study team, by **email,** regarding study related issues
   □ Withdrew consent to allow University Health Network to **mail a report**, outlining the changes in disease activity, to the home address
   □ Withdrew consent to have information contained in **medical records**, at other institutions, released to the University Health Network, Ontario Biologics Research Initiative

2. □ Lost to follow-up

3. □ Death

4. □ Other, specify:_____

Comments:_____**4**_____
_____
_____
_____
_____
_____

Completed by: **5** Print Name:_____
Signature:_____ Date: ___/____/____(dd/mm/yyyy)

Withdrawal Notification Form

1. Patient Information
Insert Site Number, Patient Number and Patient Initials.

2. Date of Last Visit
Indicate the date the patient was last seen for this study.

3. Reason for Withdrawal
Select, from the options provided, the reason the patient has chosen to withdraw from the study. If "other" is chosen, please specify the reason.

4. Additional Comments
Please feel free t o provide any additional information.

5. Completed By
Please ensure the form is signed and dated by the person who completed the form and faxed to the data management centre at the number provided.

Appendix 9: Enrollment Query Form

Ontario Biologics Research Initiative: Safety and Effectiveness Study

University Health Network
Toronto General Hospital | Toronto Western Hospital | Princess Margaret Hospital

Query Form **Date Issued: ____/____/____ (dd/mm/yyyy)**

1 Site Number: __ __ __ Patient Number: __ __ __ Patient Initials: __ __ __

2 The boxes checked below **(√)**, indicate variable(s) or evaluation(s) that were not completed on the **Enrollment Notification Form**. Please provide the correct entry on the **ORIGINAL** Enrollment Notification Form and FAX the corrected Enrollment Notification Form with this form to OBRI immediately.
IF the variable(s) or evaluation(s) being requested were not assessed at this visit and are not available, please enter **"NOT DONE".**

□ Health Card Number_____

□ Date or Age of Diagnosis_____

□ Rheumatoid Factor_____

□ Anti-CPP_____

□ Extra-Articular Feature_____

□ Has the patient ever had DMARD Therapy_____
□ Has the patient ever had Biologic Therapy_____

□ Are medications being prescribed/changed TODAY?_____

□ Is the patient discontinuing any rheumatic drug(s) today?_____
□ Name and Discontinuation code for rheumatic drug(s) being discontinued_____

□ Is the patient being prescribed NEW traditional DMARD(s) today?_____
□ Name(s) of New DMARDS?_____

□ Is the patient changing dose or route of administration of ongoing Biologic or DMARD today?_____
□ Name of Biologic or DMARD changing route or dose?_____

□ Is the patient being prescribed a NEW biologic drug today?_____
□ Name of NEW biologic?_____

□ OTHER_____
_____
_____
_____
_____

3 Verified by: Print Name:_____
Signature:_____ Date: ___/____/____(dd/mm/yyyy)

Enrollment Query Form

1. Patient Information
Site Number, Patient Number and Patient Initials will be completed by the OBRI Data Management Centre.

2. Variable / Evaluation being Queried
A list of variables or evaluations expected to be completed at Enrollment has been provided. The OBRI Data Management Centre will place a check **(√)** in the box next to the variable or evaluation that is being queried (i.e., the evaluation or variable which needs to be completed or clarified).

The site is required to respond by referring to the original Enrollment Notification Form, entering the missing information on the original Form and faxing the updated version, along with a copy of the Enrollment Query Form, to the OBRI Data Management Center immediately.

NOTE: Any new information (i.e., corrections or missing entries) should be entered on to the original form. Completing a new form will only cause more confusion.

3. Verified By
The person at the site, responsible for verifying / checking and making corrections to the original form is required to print and sign their name as well as date their signature.

Appendix 10: Assessment and Medication Query Form

University Health Network
Toronto General Hospital | Toronto Western Hospital | Princess Margaret Hospital

Ontario Biologics Research Initiative: Safety and Effectiveness Study

Query Form **Date Issued: ____/____/____ (dd/mm/yyyy)**

1 Site Number: __ __ __ Patient Number: __ __ __ Patient Initials: __ __ __

2 The boxes checked below **(√)**, indicate variable(s) or evaluation(s) which were not completed on the following assessment date; **____/____/____ (dd/mm/yyyy).**
Please provide the correct entry on the **ORIGINAL Study Assessment or Concurrent Anti-Rheumatic Medications Form** and corrected Study Assessment /Medication Form with this form to OBRI immediately. IF the variable(s) or evaluation(s) were not assessed at this visit and are not available, please enter **"NOT DONE".**

□ Physician Global Assessment_____
□ Patient Global Assessment_____
□ Co-Morbidities and serious Events_____
□ Did any of these events result in death/hospitalization/IV antibiotics/significant loss of function or disability/congenital malformation/ or was life threatening?_____
□ ESR_____
□ CRP_____
□ Date of ESR_____
□ Date of CRP_____
□ Number of / Shading of Tender Joints_____
□ Number of / Shading of Swollen Joints_____
□ Erosions on X-ray_____
□ Year of X-ray_____
□ OTHER_____
_____
_____

1. Medication Name:_____
□ Dose_____□ Route_____□ Frequency_____□ Route_____
□ Start Date:____/____/____ **(dd/mm/yyyy)** □ Stop Date: :____/____/____ **(dd/mm/yyyy)**
□ Reason for Discontinuation_____

2. Medication Name:_____
□ Dose_____□ Route_____□ Frequency_____□ Route_____
□ Start Date:____/____/____ **(dd/mm/yyyy)** □ Stop Date: :____/____/____ **(dd/mm/yyyy)**
□ Reason for Discontinuation_____

3. Medication Name:_____
□ Dose_____□ Route_____□ Frequency_____□ Route_____
□ Start Date:____/____/____ **(dd/mm/yyyy)** □ Stop Date: :____/____/____ **(dd/mm/yyyy)**
□ Reason for Discontinuation_____

□ OTHER_____
_____

3 Verified by: Print Name:_____
Signature:_____ Date: ___/____/____(dd/mm/yyyy)

Assessment and Medication Query Form

1. Patient Information
Site Number, Patient Number and Patient Initials will be completed by the OBRI Data Management Centre.

2. Variable / Evaluation being Queried
A list of variables or evaluations expected to be completed on the Study Assessment and Medication Forms has been provided. The OBRI Data Management Centre will place a check **(√) in** the box next to the variable or evaluation that is being queried (i.e., the evaluation or variable which needs to be completed or clarified).

The site is required to respond by referring to the original Study Assessment or Medication Form in question, entering the missing information on the original Form and faxing the updated version, along with a copy of the Assessment and Medication Query Form, to the OBRI Data Management Center immediately.

NOTE: Any new information (i.e., corrections or missing entries) should be entered on the original form. Completing a new form will only cause more confusion.

3. Verified By
The person at the site, responsible for verifying / checking and making corrections to the original form is required to print and sign their name as well as date their signature.