Site Number: __ __ __ __ Screening ID: __ __ __ __ - __ Participant Letters: __ __ __

**Complete this form to report:**

- **A new adverse event, or**
- **A change in intensity, frequency, or duration of a previously reported adverse event.**

**If updating a previously reported adverse event, make the necessary changes to the original report and send copies of the updated pages to the Coordinating Center. Include a copy of the first page for updates so that changes can be linked to the original Adverse Event ID Number.**

An *adverse event* is described as any unfavorable or unintended clinical event, sign, symptom, or disease, or any event that has *changed* adversely in nature, intensity, or frequency. Unless this event is a *serious adverse event*, this form should be completed at the next scheduled follow-up visit.

## A. REPORT INFORMATION

*Adverse Event ID Number:* # # # #

1. Date of report: __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)

2. Last attended study visit *(check one)*:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ 1 | Screening | ☐ 6 | Week 5 | ☐ 17 | Month 9 | ☐ 28 | Month 21 | ☐ 33 | Month 48 | | |
| ☐ 2 | Baseline | ☐ 10 | Week 10 | ☐ 18 | Month 12 | ☐ 29 | Month 24 | | | | |
| ☐ 3 | Week 1 | ☐ 11 | Month 3 | ☐ 21 | Month 13 | ☐ 30 | Month 30 | ☐ 99 | Other | | |
| ☐ 4 | Week 2 | ☐ 15 | Month 5 | ☐ 26 | Month 15 | ☐ 31 | Month 36 | ☐ 98 | PhiX174 Visit ONLY | | |
| ☐ 5 | Week 3 | ☐ 16 | Month 6 | ☐ 27 | Month 18 | ☐ 32 | Month 42 | | | | |

a. If OTHER, specify date of visit: __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)

b. If PhiX174 Visit ONLY *(i.e. Weeks 6, 7, 8, 13, 14, 16, 53, 54, 58, 59, 60, or 62)*, Record week number: __ __

3. The adverse event was first reported during *(check one)*:

| | | | |
|---|---|---|---|
| ☐ 1 | Interim Follow-up *(unplanned)* Visit | ☐ 3 | Unattended *(phone-call, etc.)* Visit |
| ☐ 2 | Routine Follow-up *(planned)* Visit | ☐ 4 | PhiX174 *(planned)* Visit ONLY |

4. How many separate adverse events are being reported at this time? __ __

IF MORE THAN 1, each adverse event requires the completion of a separate Adverse Event Report Form

## B. GENERAL EVENT INFORMATION

1. Date of onset of adverse event: __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)

2. Event Type *(check **one**)*:

**Infusion Specific**

- ☐ 1 Malaise
- ☐ 2 Fever
- ☐ 3 Cough
- ☐ 4 Shortness of Breath
- ☐ 5 Hypotension
- ☐ 6 Hypertension
- ☐ 7 Tachycardia
- ☐ 8 Rash
- ☐ 9 Pruritus
- ☐ 10 Vomiting
- ☐ 11 Nausea

**General Systems**

- ☐ 17 Allergic reaction or episode
- ☐ 18 Cancer
- ☐ 19 Hyperlipidemia
- ☐ 20 Renal Insufficiency
- ☐ 21 Psychiatric disease
- ☐ 22 Stroke/Cerebrovascular event
- ☐ 23 Myocardial Infarction/Heart Attack
- ☐ 24 Angina Pectoris
- ☐ 25 Arrhythmia
- ☐ 26 Congestive Heart Failure

*On all questions write "?" if the desired information is currently unavailable, but is being checked and will be known in future updates.*
*Write "*" if the desired information is permanently unavailable (i.e. will not be known in any future updates).*

Site: __ __ __ __ Screening ID: __ __ __ __ - __ Letters: __ __ __ Adverse Event ID Number: __ __ __ __

## B. GENERAL EVENT INFORMATION (CONTINUED)

2. Event Type *(check **one**)*: (continued)

**Infection**

- ☐ 12 Viral infection
- ☐ 13 Bacterial infection
- ☐ 14 Fungal infection
- ☐ 15 Protozoal infection
- ☐ 16 Infection of unknown cause

**Accident**

- ☐ 27 Accident requiring medical assistance, but no ER visit or hospital admission
- ☐ 28 Accident requiring ER visit, but not admission to hospital
- ☐ 29 Accident requiring admission to hospital

**Pregnancy**

- ☐ 30 Pregnancy (Complete Forms RIT14 and RIT14R)

**Diabetes Related**

- ☐ 31 Ketoacidosis w/ ER visit, but no hospital admission
- ☐ 32 Ketoacidosis requiring admission to hospital
- ☐ 33 Hypoglycemia w/ assistance, not needing injected glucagons or IV glucose, and no seizure or coma
- ☐ 34 Hypoglycemia resulting in seizure and/or coma
- ☐ 35 Need for injected glucagon or IV glucose

**Laboratory Abnormality**

- ☐ 36 Laboratory abnormality

**Other**

- ☐ 99 Other, a. Specify: _____

## C. EVENT DESCRIPTION

1. Describe the event:
*(If an infection, describe organism, sensitivity, treatment, etc.)*

_____
_____
_____
_____

2. Has the adverse event resolved? Y N

If YES,

a. Date resolved: __ __ / __ __ __ / __ __ __ __
DAY MONTH YEAR

3. What was the outcome of the adverse event? *(check one)*

- ☐ 1 Recovered, no residual effect
- ☐ 2 Residual effect, no treatment
- ☐ 3 Residual effect, being treated
- ☐ 4 Persistent, no treatment
- ☐ 5 Persistent, being treated
- ☐ 6 Death
- ☐ 99 Other, a. Specify: _____

## D. RELATIONSHIP, ACTION TAKEN, AND INTENSITY

1. Relationship to study medication (*check one*):

☐ 1 Not related ☐ 2 Unlikely ☐ 3 Possible ☐ 4 Probable ☐ 5 Definite

| | |
|---|---|
| **Not related:** | No relationship (0% chance) that AE is related to study medication |
| **Unlikely:** | Relationship is possible, but not likely (1 – 19% chance) that AE is related to study medication |
| **Possible** | Reasonable likelihood that the study medication caused the adverse event with a chance (20-50%) the AE is related that cannot be excluded |
| **Probable:** | Relationship is quite likely (51 – 99% chance) that the AE is related to the study medication |
| **Definite:** | Unquestionable relationship (100% chance) that the AE is related to the study medication |

*On all questions write "?" if the desired information is currently unavailable, but is being checked and will be known in future updates.*
*Write "*" if the desired information is permanently unavailable (i.e. will not be known in any future updates).*

Site: __ __ __ __ Screening ID: __ __ __ __ - __ Letters: __ __ __ Adverse Event ID Number: __ __ __ __

## D. RELATIONSHIP, ACTION TAKEN, AND INTENSITY (CONTINUED)

2. Actions taken for the adverse event:

| | | | | | |
|---|---|---|---|---|---|
| a. Rate change in study medication? | Y | N | e. None? | Y | N |
| b. Concomitant medication prescribed? | Y | N | f. Requested testing of viral specimens? | Y | N |
| c. Outpatient procedure? | Y | N | g. Other? | Y | N |
| d. Non-drug treatment? | Y | N | | | |

If OTHER,
1) Specify: _____

If *concomitant medication* was prescribed, complete the Concomitant Medications Form (**RIT10**)

3. Did treatment require any of the following?

| | | | | | |
|---|---|---|---|---|---|
| a. Visit to study site? | Y | N | d. In-patient rehabilitation? | Y | N |
| b. Visit to emergency room? | Y | N | e. Admission to hospital? | Y | N |
| c. Out-patient rehabilitation? | Y | N | f. Admission to skilled nursing facility? | Y | N |

If treatment involved admission to hospital, skilled nursing facility, or in-patient rehabilitation:

g. Record length of stay: __ __ __ Days

4. Did treatment of the adverse event require unmasking of the participant's treatment group assignment? Y N

If YES, a. Describe the circumstances:

_____
_____
_____
_____

5. Intensity of reported event *(check one)*:
***NOTE:*** *Use NCI Common Terminology Criteria for Adverse Events (CTCAE) to grade intensity*

☐ 1 Grade 1 ☐ 2 Grade 2 ☐ 3 Grade 3 ☐ 4 Grade 4 ☐ 5 Grade 5

| | |
|---|---|
| **Grade 1:** | A mild adverse event. The symptom may be an annoyance, but does not interfere with the participant's function, or requires no intervention. |
| **Grade 2:** | A moderate adverse event. The symptom impairs the participant's usual function, but presents no danger to the participant, or resolves with intervention. |
| **Grade 3:** | A severe adverse event resulting in hospitalization or prolongation of existing hospitalization, a persistent or significant disability/incapacity, or a congenital anomaly/birth defect. |
| **Grade 4:** | A life-threatening or disabling adverse event. |
| **Grade 5:** | A fatal adverse event. |

## E. CONCLUSION

1. Include any additional comments *(e.g. note whether or not the participant has experienced this problem before, any follow-up plans, etc.)*:

_____
_____
_____
_____

2. Was this a serious adverse event? Y N

If YES, complete the following section (Section F)
If NO, DO **NOT** complete **Section F**

*On all questions write "?" if the desired information is currently unavailable, but is being checked and will be known in future updates.*
*Write "*" if the desired information is permanently unavailable (i.e. will not be known in any future updates).*

Site: __ __ __ __ Screening ID: __ __ __ __ - __ Letters: __ __ __ Adverse Event ID Number: __ __ __ __

**F. SERIOUS EVENT DESCRIPTION (This section only needs to be completed for Serious Adverse Events)**

A **Serious Adverse Event** is defined as occurrence of one or more of the following:

- An event that is of intensity **Grade 3, 4,** or **5**
- An overdose
- Any other condition that in the opinion of appropriate medical personnel will result in one of the above outcomes if left untreated
- Death
- Any life threatening condition
- Inpatient hospitalization or prolongation of current hospitalization
- Significant disability or incapacity
- Congenital anomaly/birth defect *(only if the offspring was exposed to the study medication in utero)*

All **Serious Adverse Events** must be reported to the Coordinating Center within **24 hours.**
All **Serious Adverse Events** also require the completion of the **TrialNet MedWatch Form**, which must be faxed to the Coordinating Center at **(866) 804-6058** or **(301) 468-1676** within **24 hours** of clinic notification.

1. Did the adverse event result in any of the following?
   a. Require or prolong hospitalization? Y N
   b. Death? Y N
   c. Permanent or severe disability? Y N

   IF ADVERSE EVENT RESULTED IN DEATH:

   1) Date of death: __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)

   2) Probable cause of death: _____

An adverse event resulting in death requires completion of the Mortality Event Form (**RIT13M**)

2. Was the serious adverse experience:
   a. Congenital anomaly? Y N
   b. Cancer? Y N
   c. Life-threatening? Y N
   d. Due to overdose of study medication? Y N
   e. Condition that could have resulted in one of the previous outcomes if left untreated? Y N

3. Describe the adverse event in detail *(include information leading up to the event, procedures or tests completed, date stopped study medication, etc.)*:

_____
_____
_____

4. Was this an "unexpected" adverse event? Y N

An **unexpected adverse event** is defined as one for which the specificity or severity of which is not consistent with the current Investigator's Brochure. For a complete list of expected adverse events for rituximab see the Manual of Operations.

5. Date the TrialNet MedWatch Form was faxed to the Coordinating Center: __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)

   a. Time the TrialNet MedWatch Form was faxed (24-hour clock): __ __ : __ __ (HH : MM)

**REPORTING OF ADVERSE EVENTS**

Complete this form with as much information as is currently known regarding the adverse event. If information for a question is currently unavailable but will be known, answer with a "?". If information is permanently unknown, and the answer to the question will be unknown in all future updates, answer with an "*". No questions should be left blank.

**Initials (first, middle, last) of person completing this form:** __ __ __ (F M L)

**Date form completed:** __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)

*On all questions write "?" if the desired information is currently unavailable, but is being checked and will be known in future updates.*
*Write "*" if the desired information is permanently unavailable (i.e. will not be known in any future updates).*