Form	Form Version	Version Date
Visit 1: Registration		
A0	Registration/ Eligibility Checklist	v3.0 10-13-2010
V1	Visit 1 Evaluation Form	v5.0 11-12-2010
TX	Prior Therapies Form	v2.0 01-20-2010
Visit 2: *within 14 days prior to tx*		
V2	Visit 2 Evaluation Form	v2.0 02-04-2010
MH	Baseline Abnormalities Form	v1.0 12-04-2009
EX	FMISO Administration Form	v2.0 12-06-2010
TA	FMISO PET/CT Technical Assessment Form	v5.0 12-07-2010
BS	FMISO Blood Sampling Form	v4.0 12-06-2010
SA	FMISO Safety Assessment Form	v2.0 12-06-2010
MR	MRI/MRS Form	v4.0 12-07-2010
Visit 2a- *15 participants only within 7 days of V2, prior to tx*:		
VA	Visit 2a Evaluation Form	v2.0 12-07-2010
MH	Baseline Abnormalities Form	v1.0 12-04-2009
EX	FMISO Administration Form	v2.0 12-06-2010
TA	FMISO PET/CT Technical Assessment Form	v5.0 12-07-2010
BS	FMISO Blood Sampling Form	v4.0 12-06-2010
SA	FMISO Safety Assessment Form	v2.0 12-06-2010
Follow up-*every 3 months for up to 5 years*		
F1	Follow up Form	v3.0 12-17-2010
Tissue Transmittal		
TT	Tissue Transmittal Form	v1.0 06-18-2010
End of Study		
DS	Off Study Form	v1.0 05-06-2010
Additional Forms		
PR	Protocol Variation Form	v2.0 12-07-2010
AE	Adverse Event Form	v1.0 06-18-2009
RE	Comments/Remarks Form	v2.0 12-04-2009
AI	Additional Imaging Form	v2.0 06-17-2010
AI	Supplemental Additional Imaging Form	v2.0 06-17-2010
AT	Additional Treatment Form	v3.0 10-13-2010
AT	Supplemental Additional Treatment Form	v2.0 10-15-2010
T4	Treatment Interruptions Form	v4.0 10-13-2010
T4	Supplemental Treatment Interruptions Form	v3.0 10-15-2010
MH	Supplemental Baseline Abnormalities Form	v1.0 12-04-2009
CO	Concomitant Medications Form	v1.0 07-16-2010
CO	Supplemental Concomitant Medications Form	v1.0 07-19-2010

GENERAL FORM COMPLETION INSTRUCTIONS

General Form Completion Instructions

The purpose of this document is to provide the study assigned site research associates, site investigator, and all other study assigned site staff with a general outline for completing ACRIN 6684 study forms. Form specific completion guidelines can be found on the protocol website (www.acrin.org/6684_protocol.aspx). All study staff must be familiar with Good clinical practices (GCPs) as determined by the International Conference on Harmonization (ICH).

Forms may be completed by any assigned member of the study staff that has signed the Signature Form in the Clinical Trial Book unless otherwise indicated on the form instructions (ex. the PET/CT Technologist must complete the TA form).

All questions related to any of the forms should be directed to ACRIN Data Management.

Please see Study Contact Personnel available on ACRIN's 6684 website.

Contents

GENERAL FORM COMPLETION INSTRUCTIONS

Specific elements found on most ACRIN 6684 forms

Element #'s Each question on the form is stored in ACRIN's database as an element number. They are found next to the corresponding question/element in brackets (e.g., [1]) on the paper version of the form.

Note: In some instances the question number will not correspond to the element number.

Date: Unless otherwise noted, dates are recorded in MM-DD-YYYY format, where MM is the two-digit month (*i.e.*, enter 01 for January), DD is the two-digit day, and YYYY is the year.

Time: Time is entered using the 24-hour clock (military time). Times are recorded in hh-mm format, where hh is the two-digit hour, and mm is the two-digit minute. Use leading zeros as necessary. *Example: 6:30 P.M. will be recorded as 18:30.*

Initials of person completing the form: Initials of person(s) responsible for reviewing the data and completing form. This may be different than the person web entering the form. Web entry is tracked electronically though the sign in screen.

Corrections

Corrections must be made in ink by crossing out the incorrect entry with a single horizontal line on the web entry confirmation or the completed paper form. GCP-Place the correct information next to the error, and providing an initial and date next to the correction. Do not backdate. **Do not** use any type of correction fluid or erase any entries on the forms. **All revisions must be faxed to ACRIN Data Management.**

Form Completion (Paper and Web)

Data can be entered directly from primary source document (*i.e.*, subject charts, pathology reports), the completed study paper form, or direct web entry. All reports used as source must be signed, final versions. Preliminary reports will not be accepted during monitoring or auditing.

All source must have the signature and date of the person responsible for the source document, including paper versions of the study forms.

In the case of direct web entry the data entry confirmation must be printed, verified, signed, and dated by the study research staff that entered the data and/or the investigator then stored in the patient case to be considered source documentation.

NOTE: All source documents must be available for verification during routine monitoring and auditing visits.

The information documented on the web entered form **must be identical** to the information found in the primary source document.

Read all question responses thoroughly, instructions for completing the rest of the form can be found in the parentheses next to the selected responses. Further clarifications can be found in the specific form completion instructions available on 6684 data forms website.

Answer all questions unless otherwise specified, do not leave mandatory questions blank. If any required information is missing or unknown, contact ACRIN data management to resolve. Web entry may be disrupted due to required missing/unknown data.

GENERAL FORM COMPLETION INSTRUCTIONS

Form completion, contd.

Boxes (□) are used in a 'check all that apply question' and radio buttons (○) are used in a 'select only one response' question.

Paper form completion: When boxes or radio buttons are provided for your response, please be sure to clearly mark with a ✖ or ✓. Make sure your mark is unambiguous.

Do not write in the margins of the paper forms. Any relevant additional information may be provided in the appropriate "comments" section. Note: The comment section is not intended for data analysis

Please use the 'other specify' options only when an applicable answer is not found in the rest of the code table

All forms should be submitted to ACRIN via web at www.acrin.org within 2 weeks of the participants' evaluation.

Please note that the 'due date' found on the participant calendar is not set up to be equal to the date the visit/follow-up should occur but is equal to 2 weeks after the date the visit/follow-up should occur per protocol.

Multiple Occurring Forms (MH, AE, RE, AI, AT, T4)

Note: These forms are set up to appear as a table of multiple rows on the paper versions of the forms. During web entry, one row appears at a time. Additional rows are accessed through the data collection screen.

These, with the exception of the MH (which must be completed at each Visit), will be added to the case calendar through form triggers or a request must be sent to the Data Manager to add to the calendar. Refer to the form specific completion instructions for more details.

A separate form, with a separate due date, should be completed for each applicable time point.

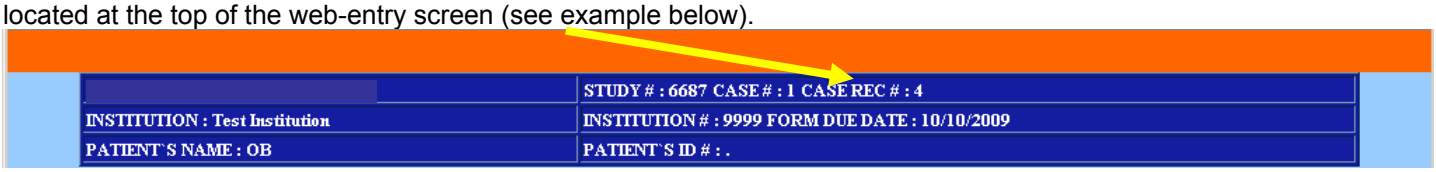
Example: A treatment interruption recorded at Visit 3 should be recorded on a separate T4 form than any interruptions recorded on Visit 4. There will be 2 T4 forms on the calendar, each with a due date that corresponds to the visit form due date.

Data should be entered on these forms with attention paid to the sequence # and due date. Each sequence # represents one row for the form.

Example: A patient has 5 treatment interruptions to report. The first row for the first recorded interruption would be entered and submitted. You would then be taken back to the main menu, where you would have to access the same T4 form (with the same due date as the 1st row) to enter the 2nd row. The sequence # is equal to the case record # found in the header of the web entry screen should be used to track the rows entered.

You will be sent one form entry confirmation for each row you enter. All of these entry confirmations will have the same form ID and due date, but will have different case record #'s.

***** Important***** When web-entering data, make sure that the "Sequence #" is equal to the "case record #" located at the top of the web-entry screen (see example below).



If the data was reported on a previous form, it should not be reported on any other subsequent form. If there are updates/revisions to the data, refer to the corrections section of this document.

A0

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO Eligibility/Registration Checklist

If this is a revised or corrected form, please √box. ☐

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

DEMOGRAPHICS

Instructions: The eligibility checklist (Part II and III of the A0) must be used to determine and confirm study eligibility status. This information is submitted to ACRIN via the website: www.acrin.org. At the time of enrollment, the participant is to review, sign and date the consent. **Note: Part I is not sequentially numbered.**

Part I. The following questions will be asked at Study Registration:

1. Initials of institutional person registering this case _____ [1]

2. Has the eligibility checklist been completed? [2]
O 1 No O 2 Yes

3. Is the participant eligible for this study? [3]
O 1 No O 2 Yes

4. Date the study-specific consent form was signed (mm-dd-yyyy) **(Must be prior to study entry)** ___-___-___ [4]

5. Participant's Initials *(last, first) (L, F)* _____ [5]

8. Date of birth [mm-dd-yyyy] ___-___-___ [8]

9. Ethnicity [9]
O 1 Hispanic or Latino O 2 Not Hispanic or Latino O 9 Unknown

11. Gender [11]
O 1 Male O 2 Female

12. Participant's country of residence **(if other, complete Q12a)** [12]
O 1 United States O 2 Canada O 3 Other

12a. Other country, specify (completed if Q12 is coded **"other"**) _____ [18]

13. Zip Code **(5 digit code, US residents)** _____ [13]

14. Participant's insurance status [14]

O	0	Other	O	5	Medicaid and Medicare
O	1	Private Insurance	O	6	Military or Veteran's Administration
O	2	Medicare	O	7	Self Pay
O	3	Medicare and Private Insurance	O	8	No means of payment
O	4	Medicaid	O	9	Unknown/Decline to answer

15. Will any component of the participant's care be given at a military or VA facility? [15]
O 1 No O 2 Yes O 9 Unknown

16. Calendar base date [Date of registration] *(mm-dd-yyyy)* ___-___-___ [16]

17. Date of registration (mm-dd-yyyy) ___-___-___ [17]

Race (check all that apply) ☐ =1 No, ☒ =2 Yes

19. ☐ American Indian or Alaskan Native [19]
20. ☐ Asian [20]
21. ☐ Black or African American [21]
22. ☐ Native Hawaiian or other Pacific Islander [22]
23. ☐ White [23]
24. ☐ Unknown [24]

INCLUSION CRITERIA

Part II. Inclusion Criteria:

25. Is the participant 18 years or older? [28]
O 1 No O 2 Yes

26. Does the participant have newly diagnosed GBM, WHO grade IV, based on pathology confirmation? [29]
O 1 No O 2 Yes

27. Does the participant have residual tumor after surgery? [30]
O 1 No O 2 Yes

NOTE: If enrolling under Amendment 1 or 2, the residual tumor must be ≥ 4cc and confirmed on MRI with T1+Gd. If enrolling under Amendment 3, amount of residual tumor will not impact eligibility and visible residual disease can include T2/FLAIR hyperintensity.

27a. Date of surgery _____-_____-_____ *(mm-dd-yyyy)* [31]

27c. Date of MRI _____-_____-_____ *(mm-dd-yyyy)* [33]

27d. Size of residual tumor: _____ [61] O cc [62]
O other, _____ [63]

28. Is the participant scheduled to receive standard fractionated radiation therapy? [34]
O 1 No O 2 Yes

29. Is the participant scheduled to receive TMZ in addition to radiation therapy? [35]
O 1 No O 2 Yes

30. Does the participant have a Karnofsky Performance Score of >60? [36]
O 1 No O 2 Yes

30a. Provide participants Karnofsky Performance Score: _____ _____ _____ [37]

10	Moribund; fatal processes progressing rapidly
20	Very sick; hospitalization necessary; active support treatment necessary
30	Severely disabled; hospitalization is indicated although death not imminent
40	Disabled; requires special care and assistance
50	Requires considerable assistance and frequent medical care
60	Requires occasional assistance, but is able to care for most of his needs
70	Cares for self; unable to carry on normal activity or to do active work
80	Normal activity with effort; some signs of symptoms of disease
90	Able to carry on normal activity; minor signs or symptoms of disease
100	Normal; no complaints; no evidence of disease

A0

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO
Eligibility/Registration Checklist

If this is a revised or corrected form, please √ box. ☐

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

Part III. Exclusion Criteria

EXCLUSION CRITERIA

31. Is the participant pregnant or breast-feeding? [38]
If female is unsure of pregnancy status, a standard urine pregnancy test should be done
O 1 No O 2 Yes

32. Is the participant scheduled to receive any chemotherapy (other than TMZ), immunotherapy, or biologic agent (including any anti-tumor investigational agent)? [39]
O 1 No O 2 Yes

32a. If yes, is the participant scheduled to receive any treatment other than a single anti-VEGF agent (in addition to the TMZ and radiation)? [60]
O 1 No O 2 Yes

32a1. If yes, is the treatment anything other than a PARP inhibitor? [64]
O 1 No O 2 Yes

33. Related to MRI capture and use of contrast agent gadolinium

33a. Is the participant claustrophobic? [40]
O 1 No O 2 Yes

33b. Does the participant have metallic objects or implanted medical devices in body?
(i.e. cardiac pacemaker, aneurysm clips, surgical clips, prostheses, artificial hearts, valves with steel parts, metal fragments, shrapnel, tattoos near the eye, or steel implants) [41]
O 1 No O 2 Yes

33c. Does the participant have sickle cell disease? [42]
O 1 No O 2 Yes

33d. Does the participant have renal failure? [43]
O 1 No O 2 Yes

33e. Does the participant have reduced renal function based on serum creatinine levels (GFR <30 mL/min/1.73m^2) obtained within 28 days prior to registration? [44]
O 1 No O 2 Yes

33e1. Date of labs _____-_____-_____ *(mm-dd-yyyy)* [45]

34. Does the participant have presence of any other co-existing condition which, in the judgment of the investigator, might increase risk to the subject? [46]
O 1 No O 2 Yes

35. Does the participant have presence of any serious systemic illness? [47]
O 1 No O 2 Yes

35a. Does the participant have an uncontrolled intercurrent infection? [48]
O 1 No O 2 Yes

35b. Does the participant have an uncontrolled malignancy? [49]
O 1 No O 2 Yes

35c. Does the participant have significant renal disease? [50]
O 1 No O 2 Yes

35d. Does the participant have any psychiatric/social situations which might impact the survival endpoint of the study or limit compliance with study requirements? [51]
O 1 No O 2 Yes

EXCLUSION CRITERIA, contd.

36. Does the participant have a history of allergic reactions attributed to compounds of similar chemical or biologic composition to FMISO (i.e., nitroimidazoles)? [52]

O 1 No O 2 Yes

37. Does the participant weigh more than 350 lbs? [53]

O 1 No O 2 Yes

38. Has the participant had prior treatment with implanted radiotherapy or chemotherapy sources (such as wafers of polifeprosan 20 with carmustine)? [54]

O 1 No O 2 Yes

Comments: _____

_____

_____

_____

_____ [56]

_____ [57]
Initials of Person(s) who determined eligibility

_____-_____-_____ [58]
Date form completed *(mm-dd-yyyy)*

_____ [59]
Initials of Person(s) completing this form

Signature of person completing form _____ *(for external use only)*

V1

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO
Visit 1 Study Procedures

If this is a revised or corrected form, please √box. ☐

ACRIN Study 6684
PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

Part I. Visit Details

1. Time point: O Visit 1 [1]

2. Date of Visit *(If visit occurred over more than one day, provide the last day procedures were performed)* ____-____-____ *mm-dd-yyyy* [2]

Part II. Study Procedures *Details of assessments must be recorded in source*

3. Study procedures completed and/or assessed as part of Visit *(check all that apply):*

* Required per protocol for all participants ** Required for all female participants of child bearing potiential

☐ * Vital Signs [3]
☐ * Karnofsky score [4]
☐ * MMSE, [5] Provide score ____ ____ ____ [6]
☐ ** Pregnancy test [7]
Date ____-____-____ mm-dd-yyyy [8]
☐ * Laboratory Tests [9]
☐ * Creatinine Levels [10]
☐ * Physical Exam [11]
☐ * Medical history [12]
☐ * Postoperative MR images [13]
☐ * Operative Reports [14]
☐ * General Neurologic Exam [15]
☐ Other imaging, [16] specify _____ [17]
☐ Other, [18] specify _____ [19]

3a. If any of the protocol required (*) visit procedures were not done provide reason: NOTE: *Complete PR form* [20]

O Participant Refusal O Not clinically indicated per treating physician
O Time constraints O Other, specify _____ [21]

4. Was MGMT methylation status performed locally? [35]

O Yes, results: O No O Unknown
O unmethylated
O methylated [36]

5. Can the participant tolerate 100% oxygen for less than 10 minutes? [37]

O Yes O No, **Participant should *not* undergo the MRI BOLD imaging sequence**

6. Is the participant undergoing the BOLD imaging sequence as part of the MRI? [38]

O Yes O No, check reason [39]
O Participant cannot tolerate O2 administration
O Site not performing BOLD sequence
O Other, specify _____ [40]

7. Does the participant's treatment plan include a single anti-VEGF agent or PARP inhibitor? [41]

O Yes, continue to Q7a O No, initial and date form

7a. Therapy being given: [42]
O Off label
O Part of other clinical trial, Name of Clinical Trial: _____ [43]

7b. Check drug type and check drug name: [48]

O Anti-VEGF agent [44]
O Bevacizumab
O Aflibercept
O Vandetanib
O XL184
O Blinded clinical trial
O Other, specify: _____ [46]

O PARP inhibitor [49]
O BSI
O ABT-888
O Blinded clinical trial
O Other, specify _____ [50]

7b1. If blinded clinical trial is checked as drug name, provide the time frame treatment details will be unblinded:

_____ [45]

7c. Intended dosing schedule: _____ [47]

_____ [33]
Initials of person(s) completing this form

____-____-____ [34]
Date form completed *(mm-dd-yyyy)*

ACRIN 6684

V1 FORM COMPLETION INSTRUCTIONS

Visit 1 Study Procedures

The V1 form is required for all participants and should be completed at the Registration/Eligibility visit. This form collects the details of the procedures collected and/or assessed as part of the visit. All details must be kept in source.
Please refer to the General Form Completion Guidelines for more details on completion of ACRIN forms.

Please contact Data Management for all form related questions.

Part I. Visit Details

2. Date of Visit If the listed study procedures occurred over more than one day, the last day of the last procedure/assessment should be used

Part II. Study Procedures

3. Study Procedures completed and/or assessed as part of Visit
Check all the boxes next to the procedures/assessments that were done as part of Visit 1. The * indicates protocol required procedures/assessments.

The MMSE score must be provided if it is checked as assessed
Pregnancy test **It is *required by protocol* that all female participants of child bearing potential must have a pregnancy test done prior to enrollment.

4. Was MGMT methylation status performed locally?
In the event the local MGMT methylation status was done, provide the results here.

7. Does the participant's treatment plan include a single anti-VEGF therapy? *Please note that this question should only be answered 'yes' for participants enrolled under amendment 2 of the protocol.*
In the event the participant is planning to use a single anti-VEGF therapy as part of their treatment, the details must be provided in Q#7a, #7b, and #7c. Multiple anti-VEGF agents are *not* allowed per protocol.

7a. Anti-VEGF being: ○**Off Label** Select if the drug is not being given as part of a clinical trial
○**Part of other clinical trial, Name of Clinical Trial**:_____
Provide the clinicaltrials.gov identifier or Official Title

7b. Drug Name: ○ **Bevacizumab**
○ **Aflibercept**
○ **Vandetetanib**
○ **XL184**
○ **Blinded clinical trial, provide time frame tx details will be unblinded**:
The estimated time frame that the treatment details will be provided to ACRIN is required. If this is unknown, contact DM.
○ **Other, specify**:_____

7c. Intended dosing schedule: _____
The intended dosing schedule of the agent is required whether the participant is receiving the drug off label or as part of a clinical trial.
This should be provided as dose (if known), method of administration, days given, cycle length.
For example: 5mg/kg IV over 90min, Day 1 and 22 for 6 week cycle

TX

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO

Prior Therapies

If this is a revised or corrected form, please √box. ☐

ACRIN Study **6684**

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

1. Did the participant ever receive any type of cancer treatment (chemotherapy, hormonal therapy, surgery, vaccine, etc)? [1]

O No, initial and date form
O Yes, complete table

Therapy Type	Any Therapy?	# Prior Chemo Regimens
Anti-Retroviral Therapy	O No O Yes O Unknown [2]	
Antisense	O No O Yes O Unknown [3]	
Bone Marrow transplant	O No O Yes O Unknown [4]	
Chemotherapy (NOS)	O No O Yes O Unknown [5]	☐ Unknown [26] [6]
Chemotherapy multiple agents systemic	O No O Yes O Unknown [7]	☐ Unknown [27] [8]
Chemotherapy non-cytotoxic	O No O Yes O Unknown [9]	☐ Unknown [28] [10]
Chemotherapy single agent systemic	O No O Yes O Unknown [11]	☐ Unknown [29] [12]
Drug and/or immunotherapy	O No O Yes O Unknown [13]	
Gene Transfer	O No O Yes O Unknown [14]	
Hematopoietic stem cell transplantation	O No O Yes O Unknown [15]	
Hormonal therapy	O No O Yes O Unknown [16]	
Image directed local therapy	O No O Yes O Unknown [17]	
Oncolytic Virotherapy	O No O Yes O Unknown [18]	
Prior Therapy (NOS)	O No O Yes O Unknown [19]	
Radiation Therapy	O No O Yes O Unknown [20]	
Surgery	O No O Yes O Unknown [21]	
Therapy (NOS)	O No O Yes O Unknown [22]	
Vaccine	O No O Yes O Unknown [23]	

_____ [24]
Initials of person(s) completing this form

_____-_____-_____ [25]
Date form completed *(mm-dd-yyyy)*

Prior Therapies

The TX form is required for all participants. The form should be completed as part of the registration visit/eligibility assessment. It collects any ***prior*** cancer related therapy/treatment the participant has had.

Note: Ideally all prior therapy would be made available in the participant's medical history.

1. Did the participant ever receive any type of cancer treatment (chemotherapy, hormonal therapy, surgery, vaccine, etc.?

No The participant has not had any prior cancer related treatment. Initial and date the form.

Yes The participant has received some type of cancer related treatment. Complete the entire table

Note: Any prior cancer treatment the participant may have received to make them eligible for this study should be reported on this form, including surgery.

Completing the Prior Therapies Table

Note: NOS= Not Otherwise Specified

Therapy Type Please see table below for the definitions and examples of the listed therapy types

Any Therapy? **No** Select if it is known that participant has not received the corresponding therapy type.

Yes Select if it is known that the participant has received the corresponding therapy type. Note that yes can be selected for more than one type.

Unknown Select if it is unknown whether the participant has ever had the corresponding therapy type.

 # Prior Chemo Regimens A regimen is described as a distinctive planned collection of agent(s) and or modalitie(s) to be utilized together during a cycle or course of therapy. The total number should include a chemotherapy that was discontinued for any reason. If a prior treatment was ABVD/CHOP, it should be coded as one chemotherapy regiment.

Note: The total number of other prior therapy types (e.g., surgery) is not required here and should not be included in this number. This should not include future regimens and/or regimens started as part of the study.

Therapy Type	CDUS Meaning	Examples
Anti-Retroviral Therapy	Agents administered to control the replication and/or spread of viruses	
Antisense	Treatment with an agent that prevents or impairs the translation of the genetic message for production of a specific protein.	
Bone Marrow Transplant	High dose chemotherapy combined with transplantation of bone marrow cells	allogeneic, syngeneic, autologous bone marrow or periperhal blood stem cell transplantation
Chemotherapy (NOS)	Non-systemic chemotherapy treatment (e.g., intra-peritoneal, intra-cavitary, intra-thecal), or chemotherapy not described by Chemotherapy Single Agent Systemic or Multi-Agent Systemic.	

Therapy Type	CDUS Meaning	Examples
Chemotherapy multiple agents systemic	Systemic chemotherapy with a regimen containing multiple agents. A regimen is described as a distinctive collection of agent(s) and/or modalities to be utilized together during a cycle or course of thera-py. All routes of administration are acceptable as long as the agent is intended for systemic therapy.	
Chemotherapy non-cytotoxic	Prior therapy with agents that are not known to cause damage to cycling cells	endostatin, mmpi, bevacizumad
Chemotherapy single agent systemic	Systemic chemotherapy with a single agent regimen. A regimen is described as a distinctive collection of agent(s) and/or mod-alities to be utilized together during a cycle or course of therapy. All routes of administration are acceptable as long as the agent is intended for systemic therapy.	
Drug and/or immunotherapy	Biologic cancer therapy. Manipulation of the body's immune system, either directly or indirectly, with therapeutic intent, e.g., tumor vaccines, monoclonal antibodies, cytokines . Do not include biologic therapy as supportive care (e.g., G-CSF for immuno-protection).	interferons, interleukins, tumor necrosis factor
Gene Transfer	Treatment of human disease by gene transfer	
Hematopoietic Stem Cell Transplantation	The intravenous infusion of autologous or allogeneic stem cells collected from the bone marrow, peripheral blood, or umbilical cord blood to re establish hematopoietic function in patients with damaged or defective bone marrow or immune systems.	
Hormonal Therapy	Cancer therapy which incorporates hormonal manipulation	tamoxifen, androgen deprivation
Image directed local therapy	A technique whereby an imaging method is used to diagnose, localize and/or treat a carcinogenic lesion, for example, a breast lump. A non-palpable carcinoma may be diagnosed by image directed biopsy or needle localization. Breast conserving surgery can be conducted with pre surgical localization with a guide wire using a diagnostic imaging method.	
Oncolytic Virotherapy	Anticancer treatment with a live, replication-competent virus	
Prior Therapy (NOS)	Prior therapy not otherwise specified	
Radiation Therapy	Targeted ionizing radiation therapy utilizing radioactive im-plants or seeds. Includes both extensive and limited radiation	
Surgery	Surgical procedure, or operation, with therapeutic intent. Do not include diagnostic procedures (e.g., biopsy).	
Therapy (NOS)	A therapy used prior for which none of these selections is appropriate.	Cryotherapy, phototherapy
Vaccine	Substance or group of substances administered to induce the immune system to recognize and destroy tumors or microorganisms.	

V2

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO
Visit 2 Study Procedures

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

If this is a revised or corrected form, please √box. ☐

Part I. Visit Details

1. Time point: [1] O Visit 2

2. Was visit completed? [2] O Yes O No, check reason *(then initial and date form)* [3]
O 1 Time constraints
O 2 Participant withdrew
O 88 Other, specify _____ [4]

3. Date of Visit *(Date study procedures were completed/assessed)* _____-_____-_____ *mm-dd-yyyy* [5]

4. Date of PET scan _____-_____-_____ *mm-dd-yyyy* [6]
☐ PET not done (complete PR form) [28]

5. Date of MRI scan _____-_____-_____ *mm-dd-yyyy* [7]
☐ MRI not done (complete PR form) [29]

Part II. Study Procedures

Details of assessments must be recorded in source

6. Study procedures completed and/or assessed as part of Visit *(check all that apply):*

* Required per protocol for all participants ** Required for all female participants of child bearing potiential

☐ * Vital Signs [8]
☐ Karnofsky score, [9] Provide score _____ _____ _____ [10]
☐ MMSE, [11] Provide score _____ _____ _____ [12]
☐ ** Pregnancy test, [13] Date _____-_____-_____ *mm-dd-yyyy* [14]
☐ Laboratory Tests [15]
☐ Creatinine Levels [16]
☐ Physical Exam [17]
☐ Medical history [18]
☐ MR images [19]
☐ Other imaging, [20] specify _____ [21]
☐ Other, [22] specify _____ [23]

6a. If any of the protocol required (*) visit procedures were not done provide reason: [24]
NOTE: *Complete PR form*

O Participant Refusal
O Time constraints
O Not clinically indicated per treating physician
O Other, specify _____ [25]

_____ [26]
Initials of person(s) completing this form

_____-_____-_____ [27]
Date form completed *(mm-dd-yyyy)*

MH

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO
Baseline Abnormalities

ACRIN Study **6684**

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

If this is a revised or corrected form, please √ box. ☐

BASELINE ABNORMALITIES

NOTE: Do not record any prior cancer treatment/therapies on this form. Record all on the TX form.

Check "none" if there are no abnormalities to report

☐ None[1]

Sequence # [2]	Condition / Event [3]	Online CTCAE/MedDRA Term [4]	Grade (1 = Mild, 2 = Moderate, 3 = Severe, 4 = Life threatning or disabling, 99 = Unknown) [5]
1			O 1 O 2 O 3 O 4 O 99
2			O 1 O 2 O 3 O 4 O 99
3			O 1 O 2 O 3 O 4 O 99
4			O 1 O 2 O 3 O 4 O 99
5			O 1 O 2 O 3 O 4 O 99
6			O 1 O 2 O 3 O 4 O 99
7			O 1 O 2 O 3 O 4 O 99
8			O 1 O 2 O 3 O 4 O 99
9			O 1 O 2 O 3 O 4 O 99
10			O 1 O 2 O 3 O 4 O 99
11			O 1 O 2 O 3 O 4 O 99
12			O 1 O 2 O 3 O 4 O 99

*****Important: If there are additional records to report, list on Supplemental MH form.*****

MH

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO
Supplemental Baseline Abnormalities

ACRIN Study **6684**

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

If this is a revised or corrected form, please √ box. ☐

SUPPLEMENTAL BASELINE ABNORMALITIES

NOTE: Do not record any prior cancer treatment/therapies on this form. Record all on the TX form.

Check "none" if there are no abnormalities to report

☐ None[1]

Sequence # [2]	Condition / Event [3]	Online CTCAE/MedDRA Term [4]	Grade (1 = Mild, 2 = Moderate, 3 = Severe, 4 = Life threatning or disabling, 99 = Unknown) [5]
1			O 1 O 2 O 3 O 4 O 99
2			O 1 O 2 O 3 O 4 O 99
3			O 1 O 2 O 3 O 4 O 99
4			O 1 O 2 O 3 O 4 O 99
5			O 1 O 2 O 3 O 4 O 99
6			O 1 O 2 O 3 O 4 O 99
7			O 1 O 2 O 3 O 4 O 99
8			O 1 O 2 O 3 O 4 O 99
9			O 1 O 2 O 3 O 4 O 99
10			O 1 O 2 O 3 O 4 O 99
11			O 1 O 2 O 3 O 4 O 99
12			O 1 O 2 O 3 O 4 O 99

*****Important: If there are additional records to report, list on Supplemental MH form.*****

ACRIN – 6684 FORM COMPLETION INSTRUCTIONS

Baseline Abnormalities Form

MH Completion Instructions

Additional form completion instructions can be found in the general form instructions document available on the ACRIN 6684 website. ***Contact data management for all form related questions/clarifications.***

The MH (Baseline Medical History Abnormalities) Form is required for each participant on the ACRIN 6684 study and is completed as part of each FMISO imaging visit (Visit 2, 2a, 3, and 4). **The MH form is to be completed *prior* to the FMISO injection**.
If using the paper, use the "Supplemental Baseline Medical History Abnormalities" form if there are more than 12 Abnormalities to record.

Definition of Baseline Abnormality:
As defined by CTEP, a baseline abnormality is any abnormal assessment (e.g., physical finding, subjective complain, or diagnostic test abnormality) identified as part of the pre-study work up for which a CTC/CTCAE term exists.
Patient Diagnosis and/or pre-existing conditions should not be submitted as baseline abnormalities.
For this study, baseline abnormalities should be assessed as part of each imaging visit, prior to FMISO injection.

If there are no Baseline Medical Abnormalities to record, check "None" at the top of the form. If you are recording Baseline Medical Abnormalities, leave "None" blank. Do not complete any additional sequences.

***Please note that all adverse events as defined in the Protocol Section 12.0 must be reported on an AE form.**

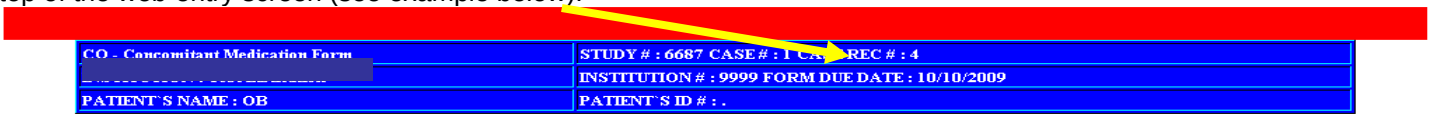
***Any abnormal assessment that is identified after the FMISO injection should be treated as a possible adverse event. Contact DM for any questions regarding adverse event or baseline abnormality reporting.**

***In the event a baseline abnormality worsens after the participant receives the FMISO, it should be treated as a possible adverse event.**

Web Form Completion Instructions:

Please note that the MH form will remain on the data collection screen, even after entry is complete. Always note the case record # to ensure duplicate entry does not occur.

"Sequence #" Column:
***** Important***** When web-entering data, make sure that the "Sequence #" is equal to the "case record #" located at the top of the web-entry screen (see example below).



"Online CTCAE/MedDRA Term" Column: This column will be left blank on the paper form. On the web-entry screen, this field requires an online look-up into the National Cancer Institute's (NCI) Common Toxicology Criteria for Adverse Events (CTCAE) data table.

1. Select the blue 'Adverse Event' button next to the "AE Short Name (online look-up)" field.
2. You will then be taken to another page with three fields:
    a. Category: you can select the drop down list which will include all terms in the selected

category;
Once the category is selected:

i. Code Description: you can filter further by entering partial term and or the entire term;
OR
ii. MedDRA Term: you can filter further by entering partial term and or the entire term.

3. Select the blue 'Retrieve' button to obtain a list of code descriptions.
4. Review the code description and MedDRA term and select the appropriate code number of the reported AE.
5. Once selected, MedDRA code number will be populated in the AE Short Name field. The MedDRA term will be displayed in red to the right of the AE Short Name field on the web entry screen when you are returned to the form.

"Grade": Select the abnormality grade based on the National Cancer Institute's (NCI) Common Toxicology Criteria for Adverse Events (CTCAE).

Grade 1 = Mild

Grade 2 = Moderate

Grade 3 = Severe

Grade 4 = Life threatening or disabling

"99" if grade is unknown

Select the MH form in the "Data Collection" screen to record subsequent Baseline Medical History Abnormalities; (example: Sequence #: 2 - case record #2). Until further notice, this process must be followed for every Abnormality being recorded.

EX **ACRIN 6684**
Imaging Agent Administration
Treatment Exposure Form

ACRIN Study **6684**
PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

Imaging Agent: FMISO

If this is a revised or corrected form, please √ box. ☐

Exam Data

1. Planned time point:[1]
- o Visit 2
- o Visit 2a

2. Was imaging agent administered?[2]
- o No (Initial & date form)
- o Yes

3. Imaging agent name:[3]
- ● FMISO

4. Administration date:[4]
_____ - _____ - _____ (mm-dd-yyyy)

Imaging Agent Procurement

5. Identification number (Lot #):[5] _____

6. Source of agent:[6]
- o Prepared in-house (provide method by which agent is synthesized, complete Q6a)
- o Obtained from outside supplier (complete Q6b)

6a. Method:[7] _____

6b. Supplier:[8] _____

Injection Information

7. Route of administration:[9] ● IV

8. Activity in full syringe before injection: ___.___ mCi[10]

8a. Time of assay of full syringe before injection: __:__ (military time)[11] ☐ Unknown[12]

9. Time of injection: __:__ (military time)[13] ☐ Unknown[14]

10. Residual activity in syringe after injection: ___.___ mCi[15] ☐ Unknown[16]
(if unknown, skip to Q12)

10a. Time of assay of residual activity after injection: __:__ (military time)[17] ☐ Unknown[18]

11. Net activity administered (Dosage Amount): ___.___ mCi[19]

12. Site of injection:[20]
- O Right antecubital
- O Right wrist
- O Right foot
- O Indwelling central catheter
- O Left antecubital
- O Left wrist
- O Left foot
- O Unknown
- O Other, specify[21] _____

13. Any infiltration at injection site noted?[22]
- O None
- O Minor (estimated to be less than 20% of dose)
- O Severe (estimated to be more than 20% of dose)

_____
Initials of person who completed form [23]

_____-_____-_____
Date form completed (mm-dd-yyyy)[24]

TA

ACRIN 6684
Tumor Hypoxia in Glioblastoma using FMISO
Local Technical Assessment Form

Imaging Agent: FMISO

If this is a revised or corrected form, please √box. ☐

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

Exam Data

1. Clinical trial time point [1]
- o Visit 2
- o Visit 2a

2. Imaging Agent Name [2]
- o FMISO

3. Was imaging agent administered? [3] o No o Yes (must be reported on EX form)

4. Was imaging exam completed? [4]
- o No, imaging not completed (complete Q4a and rest of form as applicable)
- o Yes (proceed to Q5 and continue with form)

4a. *If Imaging not completed, provide reason: [5]

o Scheduling problem	o Injection site complications	o Adverse event (complete AE form)
o Equipment failure	o Claustrophobia	o Participant death
o Participant refusal	o Participant withdrew consent	o Unknown
o Medical reason	o Progressive disease	o Other, specify: _____ [6]

5. Date of imaging: [7] (mm-dd-yyyy)

_____ - _____ - _____

6. Weight

|_|_|_|.|_| kg [8]

☐ Unknown [9]

7. Height

|_|_|_| **cm** [10]

☐ Unknown [11]

Scanner

☐ Not Done [22]

1. ☐ If Visit 2a (test/retest) participant, check to confirm scanner is the same scanner used for previous protocol scans for this participant [23]

2. Has the scanner used for <u>this study</u> been qualified by ACRIN? [24]
- o No, specify reason (complete Q3): _____ [25]
- o Yes, provide ACRIN Scanner ID# (skip to Q4): _____ [26]

3. Scanner used for this exam:

3a. Manufacturer

_____ [27]

3b. Manufacturer model name/or number

_____ [28]

4. Date of last PET Scanner SUV validation: [29]

_____ - _____ - _____ (mm-dd-yyyy)

5. Daily scanner QC run on date of study? [30]
- o No o Yes

TA

ACRIN 6684
Tumor Hypoxia in Glioblastoma using FMISO
Local Technical Assessment Form

If this is a revised or corrected form, please √box. ☐

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

Well Counter

☐ Not Done [31]

1. Well counter used for this exam:

1a. Manufacturer

_____ [32]

1b. Manufacturer model name/or number

_____ [33]

2. Daily well counter QC run on date of study? [34]
o No o Yes

3. Were clocks synchronized to the PET scanner time prior to performing the scan? [35]
o No o Yes o Unknown

4. Global time piece used throughout this study? [36]
o No o Yes o Unknown

Transmission Scan

☐ Not Done [37]

1. Transmission scan type [38]
o Low Dose CT
o PET transmission

2. kVp
___ [48]
☐ Unknown [49]

3. mAs
___ [50]
☐ Unknown [51]

4. Slice Thickness of reconstructed images
__.__ mm [52]
☐ Unknown [53]

5. Length of Transmission Scan: ___ [86]
o seconds
o minutes [87]
☐ Unknown [55]

PET Emission Scan

☐ Not Done [56]

1. Acquisition mode [57] o 2D o 3D

PET Emission Scan: **Start Time** (military time) **Stop Time** (military time)

2. __:__ [60] **3.** __:__ [61]

Reconstructed Images: **4. Pixel Size:** __.__ mm [62] **5. Thickness:** __.__ mm [63]

Adverse Events

1. Any adverse events related to imaging to report for this timepoint? [82]
o No (initial and date form) o Yes (Submit AE form)

2. Does this event meet the criteria of a serious adverse event? [83]
o No o Yes

_____ [84]
Initials of person completing this form

_____-_____-_____ [85]
Date form completed (mm-dd-yyyy)

Technical Assessment

The TA form is required for each FMISO PET imaging visit (Visit 2 and Visit 2a, if applicable). In the event the participant does not come in for the visit this form should not be completed. In the event the participant comes in for the visit but does not complete imaging, this form is required.

Note: These instructions do not include all questions found on the form. Please refer to the general form completion guidelines for further instructions. Please contact Data Management with any questions.

Exam Data

4. Was imaging exam completed?

No Select if the participant did not begin the scan

Yes Select if the participant began the scan, even in the event it was not complete.

6. Weight It is required by protocol that the participant is weighed the day of imaging. Provide weight in kg.

7. Height It is required by protocol that the participants height is measured the day of imaging. Provide in cm

Scanner

□ **Not Done** Check if the scanner information was not collected.

1. □ If Visit 2a (test/retest) participant, check to confirm scanner is the same scanner used for previous protocol scans

Well Counter

□ **Not Done** Check if the well counter details were not collected.

Transmission Scan Provide the details of the transmission/attenuation scan in this section

□ **Not Done** Check if the transmission/attenuation scan was not started

1. Transmission scan type Questions 2-5 are required for both the transmission scan types

3. mAs Provide the per slice mAs or effective mAs. If the mAs is only available in a range, contact DM

5. Length of Transmission Scan Provide the length of the transmission scan and select the appropriate units (seconds or minutes)

Adverse Events

1. Any adverse events related to imaging to report for this time point? AE's for FMISO are defined as ***any signs of illness or symptoms*** that have appeared or worsened since the FMISO injection.

2. Does this event meet the criteria of a serious adverse event? If Q#1 is answered 'yes', this question is required. Refer to Section 12.2 for the definition of a serious adverse event

BS

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO

FMISO PET Blood Sampling Form

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

If this is a revised or corrected form, please √ box. ☐

1. Timepoint [1]
- O 1 Visit 2
- O 2 Visit 2a *(15 participants only)*

2. Was blood sampling completed? [2]
- O 1 No (complete Q2a, initial and date form)
- O 2 Yes (continue to Q3)

2a. Reason not done [3]
- O 1 Scan not done
- O 88 Other, specify _____ [4]

3. Date of imaging / blood sampling [5]

_____-_____-_____ *(mm-dd-yyyy)*

Part I. Preparation for Blood Sampling

☐ **1. Check box to confirm that clocks were synchronized to the PET scanner prior to performing procedures** [6]

Well Counter calibration factor

2. CF Value ____ . _____ [57] x O 10 $^{-5}$ / O 10 $^{-6}$ / O 10 $^{-7}$ uCi/cpm [58]

3. Date of calibration _____-_____-_____ [8]
(mm-dd-yyyy)

☐ **4. Check box to confirm that blood sampling was done with the IV catheter NOT used for the FMISO injection** [9]

Part II. Blood Sampling *All elements of this table are required. If any are checked unknown, complete a PR form.*

	5 minutes after start of emission scan (± 2 minutes)	10 minutes after start of emission scan (± 2 minutes)	15 minutes after start of emission scan (± 2 minutes)
Exact Time of Blood Draw *Military time*	__ __ : __ __ [10] : __ __ [59] *hh:mm:ss* ☐ Unknown [11]	__ __ : __ __ [25] : __ __ [62] *hh:mm:ss* ☐ Unknown [26]	__ __ : __ __ [40] : __ __ [65] *hh:mm:ss* ☐ Unknown [41]
Exact Start Time of Counting *Military time*	__ __ : __ __ : __ __ *hh:mm:ss* [12] [13]	__ __ : __ __ : __ __ *hh:mm:ss* [27] [28]	__ __ : __ __ : __ __ *hh:mm:ss* [42] [43]
Weight of empty gamma tube	__ __ . __ __ __ [15] o g [60] ☐ Unknown [16]	__ __ . __ __ __ [30] o g [63] ☐ Unknown [31]	__ __ . __ __ __ [45] o g [66] ☐ Unknown [46]
Weight of filled gamma tube	__ __ . __ __ __ [17] o g [61] ☐ Unknown [18]	__ __ . __ __ __ [32] o g [64] ☐ Unknown [33]	__ __ . __ __ __ [47] o g [67] ☐ Unknown [48]
Background counts (empty well counter)	__ __ __ __ __ __ . __ *cpm* [19] ☐ Unknown [20]	__ __ __ __ __ __ . __ *cpm* [34] ☐ Unknown [35]	__ __ __ __ __ __ . __ *cpm* [49] ☐ Unknown [50]
Gamma tube count (with blood sample)	__ __ __ __ __ __ . __ *cpm* [21] ☐ Unknown [22]	__ __ __ __ __ __ . __ *cpm* [36] ☐ Unknown [37]	__ __ __ __ __ __ . __ *cpm* [51] ☐ Unknown [52]
Length of Counting	__ __ : __ __ *mm.ss* [23] ☐ Unknown [24]	__ __ : __ __ *mm.ss* [38] ☐ Unknown [39]	__ __ : __ __ *mm.ss* [53] ☐ Unknown [54]

_____ [55]
Initials of person(s) completing this form

_____-_____-_____ [56]
Date form completed *(mm-dd-yyyy)*

SA

ACRIN 6684
Tumor Hypoxia in Glioblastoma using FMISO
FMISO Safety Assessment Form

ACRIN Study 6684
PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

If this is a revised or corrected form, please √box. ☐

1. Timepoint *(check one)* [1]

O 1 Visit 2
O 2 Visit 2a *(15 participants only)*

Part I. Monitoring for Physiologic Effects of FMISO *Complete entire table for each FMISO imaging scan*

Time Point of Vital Sign Reading	Time Taken *Military time*	Pulse	Blood Pressure *Systolic/Diastolic*	Respirations *Check one*	Temperature
Prior to Injection	__ __ : __ __ [2] *hh:mm* ☐ Unknown [3]	_____ bpm [4] ☐ Unknown [5]	_____ / _____ mmHg [6] [7] ☐ Unknown [8]	O Labored [9] O Unlabored O Unknown	_____ . _____ °C [10] ☐ Unknown [11]
Completion of FMISO PET Imaging	__ __ : __ __ [12] *hh:mm* ☐ Unknown [13]	_____ bpm [14] ☐ Unknown [15]	_____ / _____ mmHg [16] [17] ☐ Unknown [18]	O Labored [19] O Unlabored O Unknown	_____ . _____ °C [20] ☐ Unknown [21]

1. Did the participant require any additional monitoring of vital signs? [22]

O 1 No
O 2 Yes

1a. If yes, provide the last reading of vital signs taken before the participant left the PET facility:

Time Taken *Military time*	Pulse	Blood Pressure *Systolic/Diastolic*	Respirations *Check one*	Temperature
__ __ : __ __ [23] *hh:mm* ☐ Unknown [24]	_____ bpm [25] ☐ Unknown [26]	_____ / _____ mmHg [27] [28] ☐ Unknown [29]	O Labored [30] O Unlabored O Unknown	_____ . _____ °C [31] ☐ Unknown [32]

Part II. Adverse Events *Refer to Section 12.0 of the protocol*

1. Were any AE's reported *(as part of this Imaging visit)*? [33]

O 1 No
O 2 Yes *(Report on a AE Form)*

Provide date and time of follow-up telephone call for AE assessment (if the participant is unable to be reached detail attempts on comments form)

2. Date _____-_____-_____ *(mm-dd-yyyy)* [34]
☐ Unknown [35]

3. Time *(Military Time)* __ __ : __ __ *hh:mm* [36]
☐ Unknown [37]

_____ [38]
Initials of person(s) completing this form

_____-_____-_____ [39]
Date form completed *(mm-dd-yyyy)*

MR

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO MRI/MRS Assessment

If this is a revised or corrected form, please √ box. ☐

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

Part I. MR Visit

1. **Time point:** [1] O **Visit 2** *(baseline imaging)*

2. **Imaging completed?** [2] O **Yes, Date of imaging:**

_____-_____-_____ *mm-dd-yyyy* [3]

O **No, reason:** [4]
- O Equipment failure
- O Patient refusal
- O Medical contraindiction
- O Injection site complications
- O Claustrophobia
- O Other, specify _____ [5]

Part II. Steroid use and Renal Function Test

3. **Was the participant taking any steroids at the time of the MRI?** [6] O **Yes** O **No**

3a. If yes, provide details below:

Steroid Name	Steroid Dose Per Day	Start Date
[7] _____ ☐ Name unknown [78]	_____ Dose [8] Unit: [9] O mg O mg/mL O mcg O other, specify _____ [10]	[11] _____-_____-_____ *mm-dd-yyyy* ☐ Date unknown [79]

4. **Did the participant have a serum creatinine level within 4 weeks of this imaging visit?** [12]

O **Yes, Date of Labs** _____-_____-_____ *mm-dd-yyyy* [13] O **No**

eGFR: _____ _____ _____ . _____ [80] O ml/min/1.173m^2 [81]

O other, specify _____ [82]

5. **Subject weight** *(at time of scan):* _____ _____ _____ . _____ kg [17]

☐ Unknown / not done [18]

Part III. Scanner

6. **What magnet strength was the exam acquired on?** [19] O 1.5 Tesla O 3.0 Tesla

7. **Manufacturer/vendor the exam acquired on?** [20] O GE O Philips O Siemens

7a. Model name / number _____ [77]

8. **Has the scanner used for this study been qualified by ACRIN?** [21] O Yes O No, reason: _____ [22]

MR **ACRIN 6684**

Tumor Hypoxia in Glioblastoma using FMISO MRI/MRS Assessment

If this is a revised or corrected form, please √box. ☐

ACRIN Study **6684**

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

Part IV. Sequences Acquired

Sequence	Performed? *(check one)*
T1 weighted pre-contrast [24]	O **Yes** O **No**, *reason* [25] O Equipment failure O Claustrophobia O Other, specify _____ [26]
T2 weighted pre-contrast [27]	O **Yes** O **No**, *reason* [28] O Equipment failure O Claustrophobia O Other, specify _____ [29]
FLAIR [30]	O **Yes** O **No**, *reason* [31] O Equipment failure O Claustrophobia O Other, specify _____ [32]
BOLD [33]	O **Yes**, provide: **Initial room air mean O_2 saturation** _____ % [34] ☐ Unknown [35] **O_2 flow rate** _____ **L/min** [36] ☐ Unknown [37] **Mean O_2 saturation during hyperoxia** _____ % [38] ☐ Unknown [39] O **No**, *reason* [40] O Equipment failure O Claustrophobia O Other, specify _____ [41]
T1 Mapping [42]	O **Yes** O **No**, *reason* [43] O Equipment failure O Claustrophobia O Other, specify _____ [44]

10. Was contrast given? [45] O **Yes, Dose** [46] _____ O mL [83] O **No** O other, _____ [84]

Rate of injection: _____ cc/sec [47]

Contrast Brand: [48] O Magnevist O Optimark O Prohance O Omniscan O Dotarem O Other, specify _____ [49]

Sequence	Performed? *(check one)*
DCE [50]	O **Yes** O **No**, *reason* [51] O Equipment failure O Claustrophobia O Other, specify _____ [52]
Diffusion-weighted/diffusion tensor [53]	O **Yes** O **No**, *reason* [54] O Equipment failure O Claustrophobia O Other, specify _____ [55]

11. Was 2nd injection performed? [56] O **Yes, Dose** [57] _____ O mL [85] O **No** O other, _____ [86]

Rate of injection: _____ cc/sec [58]

Sequence	Performed? *(check one)*
DSC [59]	O **Yes** O **No**, *reason* [60] O Equipment failure O Claustrophobia O Other, specify _____ [61]
Post T1 3D [62]	O **Yes** O **No**, *reason* [63] O Equipment failure O Claustrophobia O Other, specify _____ [64]
Post T1 SE [65]	O **Yes** O **No**, *reason* [66] O Equipment failure O Claustrophobia O Other, specify _____ [67]
CSI MR Spectroscopy [68] **or** O **3D** O **2D** [75]	O **Yes, provide:** O **No**, *reason* [69] O Equipment failure O Claustrophobia **Best FWHM** ____ ____ [76] O Other, specify _____ [70]

12. Were any AE's reported? [71] O **Yes**, *record and report AE per protocol* O **No**

_____ [72] Initials of Technologist

_____ [73] Initials of person(s) completing this form

_____-_____-_____ [74] Date form completed *(mm-dd-yyyy)*

VA

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO Visit 2a Study Procedures

If this is a revised or corrected form, please √box. ☐

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

Part I. Visit Details

1. **Time point:** [1] O Visit 2a

2. **Was visit completed?** [2] O Yes O No, check reason *(then initial and date form)* : [3]
   - O 1 Time constraints
   - O 2 Participant withdrew
   - O 3 Participant did not consent to 2nd imaging
   - O 88 Other, specify _____ [4]

3. **Date of Visit** *(Date study procedures were completed/assessed)* _____-_____-_____ *mm-dd-yyyy* [5]

4. **Date of PET scan** _____-_____-_____ *mm-dd-yyyy* [6]

Part II. Study Procedures

Details of assessments must be recorded in source

1. **Study procedures completed and/or assessed as part of Visit** *(check all that apply):*

   * Required per protocol for all participants ** Required for all female participants of child bearing potiential

   - ☐ * Vital Signs [7]
   - ☐ Karnofsky score, [8] Provide score _____ _____ _____ [9]
   - ☐ MMSE, [10] Provide score _____ _____ _____ [11]
   - ☐ ** Pregnancy test, [12] Date _____-_____-_____ *mm-dd-yyyy* [13]
   - ☐ Laboratory Tests [14]
   - ☐ Creatinine Levels [15]
   - ☐ Physical Exam [16]
   - ☐ Medical history [17]
   - ☐ MR images [18]
   - ☐ Other imaging, [19] specify _____ [20]
   - ☐ Other, [21] specify _____ [22]

   1a. If any of the protocol required (*) visit procedures were not done provide reason: [23]
   NOTE: *Complete PR form*

   - O Participant Refusal
   - O Time constraints
   - O Not clinically indicated per treating physician
   - O Other, specify _____ [24]

_____ [25]
Initials of person(s) completing this form

_____-_____-_____ [26]
Date form completed *(mm-dd-yyyy)*

Visit 2a Study Procedures

The VA form is required for all participants until 15 participants have completed the test/retest FMISO scan (Visit 2a).
In the event the participant did not have the test/retest FMISO scan, complete *only* the VA form for Visit 2a. All other forms (MH, BS, EX, TA, and SA) will be removed automatically from the participant's calendar by ACRIN DM.

This form collects the details of the procedures collected and/or assessed as part of the visit. All details must be kept in source.
Please refer to the General Form Completion Guidelines for more details on completion of ACRIN forms.

Please contact Data Management for all form related questions.

Part I. Visit Details
2. Date of Visit If the listed study procedures occurred over more than one day, the last day of the last procedure/assessment should be used. This will usually equal the date of the test/retest FMISO scan.

Part II. Study Procedures
1. Study Procedures completed and/or assessed as part of Visit
Check all the boxes next to the procedures/assessments that were done as part of Visit 2a. The * indicates protocol required procedures/assessments.

The Karnofsky Score/MMSE scores must be provided if they are checked as assessed. Please do not provide the scores done as part of Visit 2, only if the scores were redone as part of Visit 2a.

Pregnancy test **It is *required by protocol* that all female participants of child bearing potential must have a pregnancy test done prior to enrollment.

MH

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO
Baseline Abnormalities

ACRIN Study **6684**

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

If this is a revised or corrected form, please √ box. ☐

BASELINE ABNORMALITIES

NOTE: Do not record any prior cancer treatment/therapies on this form. Record all on the TX form.

Check "none" if there are no abnormalities to report

☐ None[1]

Sequence # [2]	Condition / Event [3]	Online CTCAE/MedDRA Term [4]	Grade (1 = Mild, 2 = Moderate, 3 = Severe, 4 = Life threatning or disabling, 99 = Unknown) [5]
1			O 1 O 2 O 3 O 4 O 99
2			O 1 O 2 O 3 O 4 O 99
3			O 1 O 2 O 3 O 4 O 99
4			O 1 O 2 O 3 O 4 O 99
5			O 1 O 2 O 3 O 4 O 99
6			O 1 O 2 O 3 O 4 O 99
7			O 1 O 2 O 3 O 4 O 99
8			O 1 O 2 O 3 O 4 O 99
9			O 1 O 2 O 3 O 4 O 99
10			O 1 O 2 O 3 O 4 O 99
11			O 1 O 2 O 3 O 4 O 99
12			O 1 O 2 O 3 O 4 O 99

*****Important: If there are additional records to report, list on Supplemental MH form.*****

MH

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO
Supplemental Baseline Abnormalities

ACRIN Study **6684**

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

If this is a revised or corrected form, please √ box. ☐

SUPPLEMENTAL BASELINE ABNORMALITIES

NOTE: Do not record any prior cancer treatment/therapies on this form. Record all on the TX form.

Check "none" if there are no abnormalities to report

☐ None[1]

Sequence # [2]	Condition / Event [3]	Online CTCAE/MedDRA Term [4]	Grade (1 = Mild, 2 = Moderate, 3 = Severe, 4 = Life threatning or disabling, 99 = Unknown) [5]
1			O 1 O 2 O 3 O 4 O 99
2			O 1 O 2 O 3 O 4 O 99
3			O 1 O 2 O 3 O 4 O 99
4			O 1 O 2 O 3 O 4 O 99
5			O 1 O 2 O 3 O 4 O 99
6			O 1 O 2 O 3 O 4 O 99
7			O 1 O 2 O 3 O 4 O 99
8			O 1 O 2 O 3 O 4 O 99
9			O 1 O 2 O 3 O 4 O 99
10			O 1 O 2 O 3 O 4 O 99
11			O 1 O 2 O 3 O 4 O 99
12			O 1 O 2 O 3 O 4 O 99

*****Important: If there are additional records to report, list on Supplemental MH form.*****

ACRIN – 6684 FORM COMPLETION INSTRUCTIONS

Baseline Abnormalities Form

MH Completion Instructions

Additional form completion instructions can be found in the general form instructions document available on the ACRIN 6684 website. ***Contact data management for all form related questions/clarifications.***

The MH (Baseline Medical History Abnormalities) Form is required for each participant on the ACRIN 6684 study and is completed as part of each FMISO imaging visit (Visit 2, 2a, 3, and 4). **The MH form is to be completed *prior* to the FMISO injection**.
If using the paper, use the "Supplemental Baseline Medical History Abnormalities" form if there are more than 12 Abnormalities to record.

Definition of Baseline Abnormality:
As defined by CTEP, a baseline abnormality is any abnormal assessment (e.g., physical finding, subjective complain, or diagnostic test abnormality) identified as part of the pre-study work up for which a CTC/CTCAE term exists.
Patient Diagnosis and/or pre-existing conditions should not be submitted as baseline abnormalities.
For this study, baseline abnormalities should be assessed as part of each imaging visit, prior to FMISO injection.

If there are no Baseline Medical Abnormalities to record, check "None" at the top of the form. If you are recording Baseline Medical Abnormalities, leave "None" blank. Do not complete any additional sequences.

***Please note that all adverse events as defined in the Protocol Section 12.0 must be reported on an AE form.**

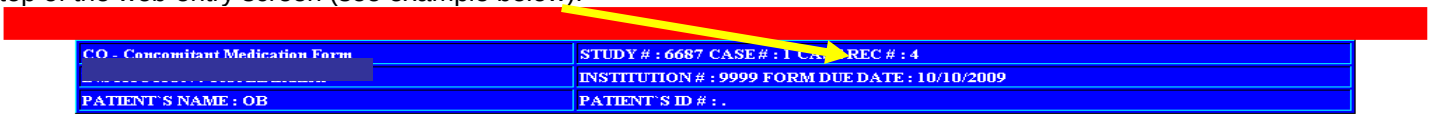
***Any abnormal assessment that is identified after the FMISO injection should be treated as a possible adverse event. Contact DM for any questions regarding adverse event or baseline abnormality reporting.**

***In the event a baseline abnormality worsens after the participant receives the FMISO, it should be treated as a possible adverse event.**

Web Form Completion Instructions:

Please note that the MH form will remain on the data collection screen, even after entry is complete. Always note the case record # to ensure duplicate entry does not occur.

"Sequence #" Column:
***** Important***** When web-entering data, make sure that the "Sequence #" is equal to the "case record #" located at the top of the web-entry screen (see example below).



"Online CTCAE/MedDRA Term" Column: This column will be left blank on the paper form. On the web-entry screen, this field requires an online look-up into the National Cancer Institute's (NCI) Common Toxicology Criteria for Adverse Events (CTCAE) data table.

1. Select the blue 'Adverse Event' button next to the "AE Short Name (online look-up)" field.
2. You will then be taken to another page with three fields:
    a. Category: you can select the drop down list which will include all terms in the selected

category;
Once the category is selected:

i. Code Description: you can filter further by entering partial term and or the entire term;
OR
ii. MedDRA Term: you can filter further by entering partial term and or the entire term.

3. Select the blue 'Retrieve' button to obtain a list of code descriptions.
4. Review the code description and MedDRA term and select the appropriate code number of the reported AE.
5. Once selected, MedDRA code number will be populated in the AE Short Name field. The MedDRA term will be displayed in red to the right of the AE Short Name field on the web entry screen when you are returned to the form.

"Grade": Select the abnormality grade based on the National Cancer Institute's (NCI) Common Toxicology Criteria for Adverse Events (CTCAE).

Grade 1 = Mild

Grade 2 = Moderate

Grade 3 = Severe

Grade 4 = Life threatening or disabling

"99" if grade is unknown

Select the MH form in the "Data Collection" screen to record subsequent Baseline Medical History Abnormalities; (example: Sequence #: 2 - case record #2). Until further notice, this process must be followed for every Abnormality being recorded.

EX **ACRIN 6684**
Imaging Agent Administration
Treatment Exposure Form

ACRIN Study **6684**
PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

Imaging Agent: FMISO

If this is a revised or corrected form, please √ box. ☐

Exam Data

1. Planned time point:[1]
- o Visit 2
- o Visit 2a

2. Was imaging agent administered?[2]
- o No (Initial & date form)
- o Yes

3. Imaging agent name:[3]
- ● FMISO

4. Administration date:[4]
_____ - _____ - _____ (mm-dd-yyyy)

Imaging Agent Procurement

5. Identification number (Lot #):[5] _____

6. Source of agent:[6]
- o Prepared in-house (provide method by which agent is synthesized, complete Q6a)
- o Obtained from outside supplier (complete Q6b)

6a. Method:[7] _____

6b. Supplier:[8] _____

Injection Information

7. Route of administration:[9] ● IV

8. Activity in full syringe before injection: ___.___ mCi[10]

8a. Time of assay of full syringe before injection: __:__ (military time)[11] ☐ Unknown[12]

9. Time of injection: __:__ (military time)[13] ☐ Unknown[14]

10. Residual activity in syringe after injection: ___.___ mCi[15] ☐ Unknown[16]
(if unknown, skip to Q12)

10a. Time of assay of residual activity after injection: __:__ (military time)[17] ☐ Unknown[18]

11. Net activity administered (Dosage Amount): ___.___ mCi[19]

12. Site of injection:[20]
- O Right antecubital
- O Right wrist
- O Right foot
- O Indwelling central catheter
- O Left antecubital
- O Left wrist
- O Left foot
- O Unknown
- O Other, specify[21] _____

13. Any infiltration at injection site noted?[22]
- O None
- O Minor (estimated to be less than 20% of dose)
- O Severe (estimated to be more than 20% of dose)

_____
Initials of person who completed form [23]

_____-_____-_____
Date form completed (mm-dd-yyyy)[24]

TA

ACRIN 6684
Tumor Hypoxia in Glioblastoma using FMISO
Local Technical Assessment Form

Imaging Agent: FMISO

If this is a revised or corrected form, please √box. ☐

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

Exam Data

1. Clinical trial time point [1]
- o Visit 2
- o Visit 2a

2. Imaging Agent Name [2]
- o FMISO

3. Was imaging agent administered? [3] o No o Yes (must be reported on EX form)

4. Was imaging exam completed? [4]
- o No, imaging not completed (complete Q4a and rest of form as applicable)
- o Yes (proceed to Q5 and continue with form)

4a. *If Imaging not completed, provide reason: [5]

o Scheduling problem	o Injection site complications	o Adverse event (complete AE form)
o Equipment failure	o Claustrophobia	o Participant death
o Participant refusal	o Participant withdrew consent	o Unknown
o Medical reason	o Progressive disease	o Other, specify: _____ [6]

5. Date of imaging: [7] (mm-dd-yyyy)

_____ - _____ - _____

6. Weight

|_|_|_|.|_| kg [8]

☐ Unknown [9]

7. Height

|_|_|_| **cm** [10]

☐ Unknown [11]

Scanner

☐ Not Done [22]

1. ☐ If Visit 2a (test/retest) participant, check to confirm scanner is the same scanner used for previous protocol scans for this participant [23]

2. Has the scanner used for <u>this study</u> been qualified by ACRIN? [24]
- o No, specify reason (complete Q3): _____ [25]
- o Yes, provide ACRIN Scanner ID# (skip to Q4): _____ [26]

3. Scanner used for this exam:

3a. Manufacturer

_____ [27]

3b. Manufacturer model name/or number

_____ [28]

4. Date of last PET Scanner SUV validation: [29]

_____ - _____ - _____ (mm-dd-yyyy)

5. Daily scanner QC run on date of study? [30]
- o No o Yes

TA

ACRIN 6684
Tumor Hypoxia in Glioblastoma using FMISO
Local Technical Assessment Form

If this is a revised or corrected form, please √box. ☐

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

Well Counter

☐ Not Done [31]

1. Well counter used for this exam:

1a. Manufacturer

_____ [32]

1b. Manufacturer model name/or number

_____ [33]

2. Daily well counter QC run on date of study? [34]
o No o Yes

3. Were clocks synchronized to the PET scanner time prior to performing the scan? [35]
o No o Yes o Unknown

4. Global time piece used throughout this study? [36]
o No o Yes o Unknown

Transmission Scan

☐ Not Done [37]

1. Transmission scan type [38]
o Low Dose CT
o PET transmission

2. kVp
___ [48]
☐ Unknown [49]

3. mAs
___ [50]
☐ Unknown [51]

4. Slice Thickness of reconstructed images
__.__ mm [52]
☐ Unknown [53]

5. Length of Transmission Scan: ___ [86]
o seconds
o minutes [87]
☐ Unknown [55]

PET Emission Scan

☐ Not Done [56]

1. Acquisition mode [57] o 2D o 3D

PET Emission Scan: **Start Time** (military time) **Stop Time** (military time)

2. __:__ [60] **3.** __:__ [61]

Reconstructed Images: **4. Pixel Size:** __.__ mm [62] **5. Thickness:** __.__ mm [63]

Adverse Events

1. Any adverse events related to imaging to report for this timepoint? [82]
o No (initial and date form) o Yes (Submit AE form)

2. Does this event meet the criteria of a serious adverse event? [83]
o No o Yes

_____ [84]
Initials of person completing this form

_____-_____-_____ [85]
Date form completed (mm-dd-yyyy)

Technical Assessment

The TA form is required for each FMISO PET imaging visit (Visit 2 and Visit 2a, if applicable). In the event the participant does not come in for the visit this form should not be completed. In the event the participant comes in for the visit but does not complete imaging, this form is required.

Note: These instructions do not include all questions found on the form. Please refer to the general form completion guidelines for further instructions. Please contact Data Management with any questions.

Exam Data

4. Was imaging exam completed?

No Select if the participant did not begin the scan

Yes Select if the participant began the scan, even in the event it was not complete.

6. Weight It is required by protocol that the participant is weighed the day of imaging. Provide weight in kg.

7. Height It is required by protocol that the participants height is measured the day of imaging. Provide in cm

Scanner

□ **Not Done** Check if the scanner information was not collected.

1. □ If Visit 2a (test/retest) participant, check to confirm scanner is the same scanner used for previous protocol scans

Well Counter

□ **Not Done** Check if the well counter details were not collected.

Transmission Scan Provide the details of the transmission/attenuation scan in this section

□ **Not Done** Check if the transmission/attenuation scan was not started

1. Transmission scan type Questions 2-5 are required for both the transmission scan types

3. mAs Provide the per slice mAs or effective mAs. If the mAs is only available in a range, contact DM

5. Length of Transmission Scan Provide the length of the transmission scan and select the appropriate units (seconds or minutes)

Adverse Events

1. Any adverse events related to imaging to report for this time point? AE's for FMISO are defined as ***any signs of illness or symptoms*** that have appeared or worsened since the FMISO injection.

2. Does this event meet the criteria of a serious adverse event? If Q#1 is answered 'yes', this question is required. Refer to Section 12.2 for the definition of a serious adverse event

BS

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO

FMISO PET Blood Sampling Form

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

If this is a revised or corrected form, please √ box. ☐

1. Timepoint [1]
- O 1 Visit 2
- O 2 Visit 2a *(15 participants only)*

2. Was blood sampling completed? [2]
- O 1 No (complete Q2a, initial and date form)
- O 2 Yes (continue to Q3)

2a. Reason not done [3]
- O 1 Scan not done
- O 88 Other, specify _____ [4]

3. Date of imaging / blood sampling [5]

_____-_____-_____ *(mm-dd-yyyy)*

Part I. Preparation for Blood Sampling

☐ **1. Check box to confirm that clocks were synchronized to the PET scanner prior to performing procedures** [6]

Well Counter calibration factor

2. CF Value ____ . _____ [57] x O 10 $^{-5}$ / O 10 $^{-6}$ / O 10 $^{-7}$ uCi/cpm [58]

3. Date of calibration _____-_____-_____ [8]
(mm-dd-yyyy)

☐ **4. Check box to confirm that blood sampling was done with the IV catheter NOT used for the FMISO injection** [9]

Part II. Blood Sampling *All elements of this table are required. If any are checked unknown, complete a PR form.*

	5 minutes after start of emission scan (± 2 minutes)	10 minutes after start of emission scan (± 2 minutes)	15 minutes after start of emission scan (± 2 minutes)
Exact Time of Blood Draw *Military time*	__ __ : __ __ [10] : __ __ [59] *hh:mm:ss* ☐ Unknown [11]	__ __ : __ __ [25] : __ __ [62] *hh:mm:ss* ☐ Unknown [26]	__ __ : __ __ [40] : __ __ [65] *hh:mm:ss* ☐ Unknown [41]
Exact Start Time of Counting *Military time*	__ __ : __ __ : __ __ *hh:mm:ss* [12] [13]	__ __ : __ __ : __ __ *hh:mm:ss* [27] [28]	__ __ : __ __ : __ __ *hh:mm:ss* [42] [43]
Weight of empty gamma tube	__ __ . __ __ __ [15] o g [60] ☐ Unknown [16]	__ __ . __ __ __ [30] o g [63] ☐ Unknown [31]	__ __ . __ __ __ [45] o g [66] ☐ Unknown [46]
Weight of filled gamma tube	__ __ . __ __ __ [17] o g [61] ☐ Unknown [18]	__ __ . __ __ __ [32] o g [64] ☐ Unknown [33]	__ __ . __ __ __ [47] o g [67] ☐ Unknown [48]
Background counts (empty well counter)	__ __ __ __ __ __ . __ *cpm* [19] ☐ Unknown [20]	__ __ __ __ __ __ . __ *cpm* [34] ☐ Unknown [35]	__ __ __ __ __ __ . __ *cpm* [49] ☐ Unknown [50]
Gamma tube count (with blood sample)	__ __ __ __ __ __ . __ *cpm* [21] ☐ Unknown [22]	__ __ __ __ __ __ . __ *cpm* [36] ☐ Unknown [37]	__ __ __ __ __ __ . __ *cpm* [51] ☐ Unknown [52]
Length of Counting	__ __ : __ __ *mm.ss* [23] ☐ Unknown [24]	__ __ : __ __ *mm.ss* [38] ☐ Unknown [39]	__ __ : __ __ *mm.ss* [53] ☐ Unknown [54]

_____ [55]
Initials of person(s) completing this form

_____-_____-_____ [56]
Date form completed *(mm-dd-yyyy)*

SA

ACRIN 6684
Tumor Hypoxia in Glioblastoma using FMISO
FMISO Safety Assessment Form

ACRIN Study 6684
PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

If this is a revised or corrected form, please √box. ☐

1. Timepoint *(check one)* [1]

O 1 Visit 2
O 2 Visit 2a *(15 participants only)*

Part I. Monitoring for Physiologic Effects of FMISO *Complete entire table for each FMISO imaging scan*

Time Point of Vital Sign Reading	Time Taken *Military time*	Pulse	Blood Pressure *Systolic/Diastolic*	Respirations *Check one*	Temperature
Prior to Injection	__ __ : __ __ [2] *hh:mm* ☐ Unknown [3]	_____ bpm [4] ☐ Unknown [5]	_____ / _____ mmHg [6] [7] ☐ Unknown [8]	O Labored [9] O Unlabored O Unknown	_____ . _____ °C [10] ☐ Unknown [11]
Completion of FMISO PET Imaging	__ __ : __ __ [12] *hh:mm* ☐ Unknown [13]	_____ bpm [14] ☐ Unknown [15]	_____ / _____ mmHg [16] [17] ☐ Unknown [18]	O Labored [19] O Unlabored O Unknown	_____ . _____ °C [20] ☐ Unknown [21]

1. Did the participant require any additional monitoring of vital signs? [22]

O 1 No
O 2 Yes

1a. If yes, provide the last reading of vital signs taken before the participant left the PET facility:

Time Taken *Military time*	Pulse	Blood Pressure *Systolic/Diastolic*	Respirations *Check one*	Temperature
__ __ : __ __ [23] *hh:mm* ☐ Unknown [24]	_____ bpm [25] ☐ Unknown [26]	_____ / _____ mmHg [27] [28] ☐ Unknown [29]	O Labored [30] O Unlabored O Unknown	_____ . _____ °C [31] ☐ Unknown [32]

Part II. Adverse Events *Refer to Section 12.0 of the protocol*

1. Were any AE's reported *(as part of this Imaging visit)*? [33]

O 1 No
O 2 Yes *(Report on a AE Form)*

Provide date and time of follow-up telephone call for AE assessment (if the participant is unable to be reached detail attempts on comments form)

2. Date _____-_____-_____ *(mm-dd-yyyy)* [34]
☐ Unknown [35]

3. Time *(Military Time)* __ __ : __ __ *hh:mm* [36]
☐ Unknown [37]

_____ [38]
Initials of person(s) completing this form

_____-_____-_____ [39]
Date form completed *(mm-dd-yyyy)*

F1

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO Follow-up

If this is a revised or corrected form, please √ box. ☐

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

Part I. Follow-up

1. Follow-up time point: [1]

O 3 month O 12 month O 21 month O 30 month O 39 month O 48 month O 57 month
O 6 month O 15 month O 24 month O 33 month O 42 month O 51 month O 60 month
O 9 month O 18 month O 27 month O 36 month O 45 month O 54 month O Final study time point

2. Date the site RA/PI contacted the treating physician for this follow-up evaluation ____-____-____ *mm-dd-yyyy* [2]
☐ Not done [3]

3. Date of last contact between the treating physician and the participant ____-____-____ *mm-dd-yyyy* [4]
☐ Unknown [5]

4. Participants vital status at the time of the follow-up: [6]

O Alive Date confirmed ____-____-____ *mm-dd-yyyy* [66]
O Dead (complete rest of form as applicable, then complete DS form)
O Unknown
Check reason unknown, then initial and date form [7]
O RA/PI did not contact treating physician
O Treating physician lost contact with patient
O Other, specify _____ [8]

5. Did the participant complete the clinical follow-up evaluation? [9]

Includes: diseases status assessment, treatment, imaging...

O Yes
O No, check reason [10]
O Scheduling problem
O Participant refusal
O Medical reason, specify _____ [11]
O Participant is in hospice
O Withdrew consent (initial and date form)
O Other, specify _____ [12]
O Not clinically indicated

Part II. Routine Clinical Follow-up Details

6. Neurological status:

6a. Karnofsky score, assessed? [13] O Yes, Score: _____ _____ _____ [14]
Date of assessment ____-____-____ *mm-dd-yyyy* [15]
O No ☐ Unknown [16]
O Unknown

6b. MMSE score, assessed? [17] O Yes, Score: _____ _____ _____ [18]
Date of assessment ____-____-____ *mm-dd-yyyy* [19]
O No ☐ Unknown [20]
O Unknown

7. Has the participant had any new treatment since the last time point? [21]

O Yes, complete Q7a table below
O No, continue to Q8
O Unknown, continue to Q8

7a. Provide details of treatment:

Treatment [22]	Treatment Description [24]	Dose	Start Date Record '99' if unknown	End Date Record '99' if unknown	Any additional treatment? [35]	Any Interruptions? [68]
O Chemotherapy O Radiation O Surgery O Anti-VEGF agent O PARP inhibitor O Other, specify: _____ [23]	_____ _____ _____	☐ Not applicable/unknown Check Units: [25] _____ Dose [26] O mg [27] O mg/kg O mcg O mg/m² O Other _____ [28]	____-____-____ mm-dd-yyyy [29] [30] [31]	____-____-____ mm-dd-yyyy [32] [33] [34] ☐ Ongoing [67]	O No, *continue to Q8* O Yes, *provide details on AT form* O Unknown, *continue to Q8*	O No O Yes, complete T4 form

F1

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO Follow-up

If this is a revised or corrected form, please √box. ☐

ACRIN Study **6684**

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

8. Has the participant had any new imaging since the last time point? [36]

O Yes, *complete Q8a table below*
O No, *continue to Q9*
O Unknown, *continue to Q9*

8a. Provide details of imaging:

Type of imaging [37]	**Date of imaging** [39]	**Was the participant taking any steroids at the time of the imaging?** [41]	**Any additional imaging assessed?** [51]
O MRI O CT O Other imaging, specify: _____ [38]	____-____-____ mm-dd-yyyy ☐ Unknown [40]	O No O Unknown O Yes, name: _____ [42] ☐ Unknown [43] Total Dose per day: _____ [44] ☐ Unknown [45] O mg [46] O mg/mL O mcg O Other _____ [47] Start date (of above dose) ____-____-____ mm-dd-yyyy [48] [49] [50] Record '99' if unknown	O No, *continue to Q9* O Yes, *complete AI form* O Unknown, *continue to Q9*

9. Has a report of progressive disease been previously reported (on the V4 or F1 form) prior to this follow-up? [52]

O Yes, *initial and date form*
O No, *complete Q9a, 9b, 9c*
O Unknown, *complete Q9a, 9b, 9c*

9a. Disease status at this assessment: *per Macdonald Radiographic Response Criteria* [53]

O Complete response
O Partial response
O Progressive disease, criteria used: *(check all that apply)*

☐ ≥ 25% increase in enhancing tumor area on MRI [54]

☐ Neurological status has worsened, as determined by: [55]

☐ MMSE and/or karnofsky score(s) [56]
☐ Other clinical signs, [57] specify _____ [58]

☐ Steroid dose stable or increased [59]

O Stable disease
O Not assessed (skip Q9b and Q9c)
O Unknown (skip Q9b and Q9c)

9b. Date of disease status assessment ____-____-____ *mm-dd-yyyy* [60]
☐ Unknown [61]

9c. Was MRI scan used to determine disease status? [62]

O Yes, *date of scan* ____-____-____ *mm-dd-yyyy* [63]
O No
O Unknown

_____ [64]
Initials of person(s) completing this form

____-____-____ [65]
Date form completed *(mm-dd-yyyy)*

Follow up Form

The participants treating physician should be contacted to collect this data or the data can be pulled from the medical chart. The participant should not be contacted directly.

The F1 form is required for all participants every 3 months after the last imaging visit (Visit 2 or 2a) for up to 5 years.
In these instructions, the follow up date is considered the date the participant was most recently confirmed alive.

Note: These instructions do not include all questions found on the form. Please refer to the general form completion guidelines for further instructions. Please contact Data Management with any questions.

Part I. Follow-up

1. Follow up time point. Select the appropriate time point the follow up data corresponds to. During web entry please refer to the visit sequence description in the header of the web form and on the data collection menu to ensure you are entering the correct follow up time point into the correct form. The due dates of the follow up forms may not coincide with the actual follow up dates.

3 month This option should be selected for the follow up visit done 3 months after the participants last imaging visit (Visit 2 or Visit 2a, if applicable)

6 month through 60 month Select the appropriate time point

The timeframe for each time point is 1 month prior to the corresponding due date to 2 months post. For example, if the 3 month is due 05/01/2010 and the 6 month 08/01/2010, the participants 7/1/10 visit would be entered into the 3 month visit.

4. Participants vital status at the time of follow up

Alive This should be selected if the participant has been confirmed alive at any date after the last follow up date

Date confirmed This is equal to the most recent date the participant has been confirmed as alive

Dead This should be selected if the participant has been confirmed dead. The rest of the form should be completed as appropriate and a DS (End of Study) form should be requested

If the site is notified of a participant's death between follow up forms, the next due F1 form should be submitted immediately.

Unknown This should only be selected if the participant's vital status since the prior follow up cannot be confirmed through any means. Skip the rest of the form and initial and date.

Submit an RE form detailing the reason.

Part II. Routine Clinical Follow-up Details

7. Has the participant had any new treatment since the last time point?

Yes Select if participant had treatment has not yet been reported on a prior F1, and/or prior AT form(s). This includes any previously reported treatment that was marked as ongoing on a prior form that has been completed. Provide the details in Q7a and any additional treatment details on an AT form.

No Select if it is confirmed the participant has not had any treatment or all treatment has been reported on a prior F1, and/or prior AT forms(s)

Unknown Select if it is unknown if the participant had any treatment

8. Has the participant had any new imaging since the last time point?

Yes Select if participant had imaging that has not yet been reported on a prior F1, and/or prior AI form(s). Provide the details in Q8a and any additional imaging details on a prior AI form.

No Select if it is confirmed the participant has not had any imaging or all imaging has been reported on a prior F1, and/or prior AI forms(s)

Unknown Select if it is unknown if the participant had any imaging

9. Has a report of progressive disease been previously reported prior to this follow up? A participant should only be reported as having progressive disease once, on one F1 form.

Yes Select if participant has previously been reported with progressive disease on a F1 form

No Select if it is confirmed progressive disease has not yet been reported for the participant. Q#9a-Q#9c are required

Unknown Select if it is unknown if progressive disease was previously reported. Q#9a-Q#9c are required

9a. Disease status at this assessment Refer to the Macdonald Radiographic Response Criteria Chart below.

- **Complete Response**
- **Partial Response**
- **Progressive Disease**
  - ***Criteria used*** Check all of the criteria used to determine the progression. Provide any criteria not listed in the other specify field
- **Stable Disease**
- **Not Assessed** Select if the participant did not have their disease status assessed
- **Unknown** Select if the participants disease status is cannot be verified

9b. Date of disease status assessment: This is the date of the imaging confirmation or other clinical confirmation

MACDONALD RADIOGRAPHIC RESPONSE CRITERIA

Response	***Enhancing Tumor Area***	***Neurological Status***	***Steroids***
Complete Response	≥ 95% decrease	Improved or Stable	Off
Partial Response	50% – 94% decrease	Improved or Stable	Stable or Decreased Dose
Progressive Disease	≥ 25% increase	Worsened	Stable or Increased Dose
Stable Disease	All other situations	All other situations	All other situations

Source: Macdonald et al. Response criteria for phase II studies of supratentorial malignant glioma. *J Clin Oncol*. 1990; 8:1277-1280.

TT

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO Tissue Transmittal Form

If this is a revised or corrected form, please √ box. ☐

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

1. Were pathology specimens sent? [1]

O No (proceed to Q1a)
O Yes (proceed to Q2)

1a. If not sent check reason, then initial and date form [2]

O Not allowed by institution
O Specimen lost
O Other, specify _____ [3]

2. Check box(es) of the pathology being *sent* and provide details

☐ **Block(s),** [4] **Number of blocks:** _____ _____ [5]

Fixative type: [6]

O Unbuffered formalin
O Buffered formalin
O Gluteraldehyde
O Ethanol
O Methanol
O B5
O Bouin's
O Zenkers
O Unknown
O Other, specify _____ [7]

Return to pathology Lab? [8] O No O Yes

Loan period: _____ [9]

☐ **Slides, number of slides:** [10] _____ _____ [11]

Fixative type: [12]

O Unbuffered formalin
O Buffered formalin
O Gluteraldehyde
O Ethanol
O Methanol
O B5
O Bouin's
O Zenkers
O Unknown
O Other, specify _____ [13]

***Before* sending the pathology specimens and reports, please check to confirm:**

☐ ALL study participants' personal identifying information (participant name, medical record number, SS#, etc.) on all of the material is de-identified. [14]

☐ Each slide/block/report is labeled with the study number, site number, patient case number [15]

The **pathology specimens, pathology report, and a copy of the completed/signed off form** should be shipped to:

Catherine Nutt
Molecular Pathology Unit
Massachusetts General Hospital
149 13th Street, Room 6014
Charlestown, MA 02129
RE: ACRIN 6684 Pathology

3. Date sent to path lab: _____-_____-_____ *mm-dd-yyyy* [16]

_____ [17]
Initials of person(s) completing this form

_____-_____-_____ [18]
Date form completed *(mm-dd-yyyy)*

Signature of person completing this form _____ *(for external use only)*

DS

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO

End of Study Disposition

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

If this is a revised or corrected form, please √ box. ☐

1. Provide reason for study disposition by selecting *one* of the following: [1]

- O 1 Protocol defined follow-up completed
- O 2 Participant lost to follow-up
- O 3 Participant refused follow-up / withdrew
- O 4 Death *(specify date and cause below)*

  Date of death: _____[2]/_____[3]/_____[4] *(mm/dd/yyyy)*

  Cause of death [5]

  - O 1 Disease Progression
  - O 88 Other, specify _____[6]
- O 6 Protocol violation: *(check all that apply)*

  - ☐ Did not meet eligibility [7]
  - ☐ Baseline pre-treatment FMISO PET and MRI not done [19]
- O 8 Study terminated by sponsor
- O 88 Other *(specify reason below)*

  Specify reason: _____[13]

2. Date of disposition: _____/_____/_____ *(mm/dd/yyyy)* [14]

3. Did the investigator review and sign off on the participant's disposition? [15]

- O 1 No
- O 2 Yes

Comments: _____[16]

_____[17]
Initials of person completing the form

_____/_____/_____[18]
Date form completed (mm-dd-yyyy)

To the best of my knowledge, the data collected for the participant are accurate and complete.

Investigator's signature _____

PR

ACRIN 6684
Tumor Hypoxia in Glioblastoma using FMISO
Protocol Variation Form

If this is a revised or corrected form, please √ box. ☐

ACRIN Study 6684
PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

1. Check the Protocol Event Being Reported: *(select only one)* [1]

- O 1 Inclusion/exclusion criteria not met at time of registration
- O 2 Imaging-related deviation (complete 1b)
- O 3 Study activity performed without participant consent (specify visit in Q6)
- O 5 Visit or follow-up procedures not performed per protocol (specify visit in Q6)
- O 6 Case enrolled under expired IRB approval / FWA
- O 8 Participant met one or more of the off-imaging criteria and was imaged
- O 88 Other, specify _____ [2]

1b. Image Related Deviation: *(select only one)* [3]

- O 1 Scan not performed according to protocol specific guidelines
- O 2 Images lost/unavailable
- O 88 Other, specify _____ [4]

2. Date the protocol deviation occurred: ____ - ____ - **20**____ (mm-dd-yyyy) [5]

3. Date the protocol deviation was discovered: ____ - ____ - **20**____ (mm-dd-yyyy) [6]

4. Describe the protocol variation:

_____ [7]

_____ [8]

5. What was done to rectify the situation and/or prevent future occurrence:

_____ [9]

_____ [10]

6. At what time point did this study deviation occur? [11]

- O Visit 1
- O Visit 2
- O Visit 2a
- O Follow-up timepoint, specify (check only one) [12]

O 3 month follow-up	O 24 month follow-up	O 45 month follow-up
O 6 month follow-up	O 27 month follow-up	O 48 month follow-up
O 9 month follow-up	O 30 month follow-up	O 51 month follow-up
O 12 month follow-up	O 33 month follow-up	O 54 month follow-up
O 15 month follow-up	O 36 month follow-up	O 57 month follow-up
O 18 month follow-up	O 39 month follow-up	O 60 month follow-up
O 21 month follow-up	O 42 month follow-up	O Final study time point

6a. Provide the visit / follow-up study procedure(s) this PR corresponds to *(check all that apply)*

- ☐ FMISO blood sampling [13]
- ☐ FMISO PET imaging [14]
- ☐ Pregnancy test [15]
- ☐ GFR levels [16]
- ☐ MRI imaging [17]
- ☐ Other, [18] specify _____ [19]

_____ [20]
Initials of person responsible for data (RA, study staff)

____ - ____ - ____ *(mm-dd-yyyy)* [21]
Date Form Completed

Signature of person completing this form _____ *(for external use only)*

AE

ACRIN Adverse Event Form
ACRIN 6684
ACRIN Assessment of Tumor Hypoxia in Glioblastoma using FMISO

If this is a revised or corrected form, please √box. ☐

ACRIN Study Case #

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

All Adverse Events (AEs) and Serious Adverse Events (SAEs) as defined in the protocol require routine reporting via web entry of the AE CRF. Only one AE is captured per form. For further instructions in completing the form, please refer to the AE completion instructions. Please note that source documentation (ACRIN AE log, ACRIN AE CRF, printed AE web confirmation, or participant's chart) must have the investigator's signature. For AE reporting requirements, please refer to the AE reporting section of the protocol. Contact ACRIN's AE coordinator for any questions.

AE Description _____ [1, 2]

AE Short Name (online look-up) _____ [3]

Grade [4]	Attribution [5]	Expectedness [6]	Serious AE? [42]	Expedited Report Submitted [7]	Action Taken (mark ☒ all that apply)	Outcome [9]	Date of AE Onset and Resolution (mm-dd-yyyy); mark ☒ the box "ongoing" if the AE is ongoing at the time of report
O Mild O Moderate O Severe O Life threatening or disabling O Fatal	O Unrelated O Unlikely O Possible O Probable O Definite	O Expected O Unexpected	O No O Yes	O No O Yes	☐ None [43] ☐ Medication therapy [44] ☐ Procedure [45] ☐ Hospitalization [46] ☐ Other [47]	O Recovered O Improved O Ongoing O Death O Unknown	Start date: ____ - ____ - ____ [10] Resolution date: ____ - ____ - ____ [11] ☐ Ongoing [12]

Comments: _____ [37], [38]

Additional AEs to report? [39]
- O No
- O Yes (Please complete an additional AE form)

Was the AE assessed, reviewed and signed by the investigator? [40]
- O No
- O Yes

____-____-____ [41]
Date form completed (mm-dd-yyyy)

_____ [50]
Investigator's initials

Investigator's signature _____ *(for external use only)*

RE

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO Comments/Remarks Form

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

If this is a revised or corrected form, please √ box. ☐

Sequence #	Form ID [1]	Date of event/procedure [2]	Comment [3]
1			
2			
3			
4			
5			

****For additional comments, use another RE form ****

AI

ACRIN 6684
Assessment of Tumor Hypoxia in Glioblastoma using FMISO

Additional Imaging

If this is a revised or corrected form, please √box. ☐

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

Sequence # [1]	**Type of Imaging** [2] specify [3]	**Date of Imaging** [4] Unknown [5]	**Was the participant taking any steroids at the time of the Imaging?** [6] Steroid name [7] Dose unknown [9] Steroid name unknown [15] Dose units [10] Steroid dose [8] Units, other specify [11] Start Date: Month [12] - Day [13] - Year [14] Record '99' if unknown
1	O MRI O CT O Other imaging, specify _____	_____-_____-_____ mm-dd-yyyy ☐ Unknown	O No O Unknown O Yes, name _____ ☐ Unknown Total dose per day: _____ ☐ Unknown O mg O mg/mL O mcg O other, specify _____ Start Date (of above dose) _____-_____-_____ mm-dd-yyyy
2	O MRI O CT O Other imaging, specify _____	_____-_____-_____ mm-dd-yyyy ☐ Unknown	O No O Unknown O Yes, name _____ ☐ Unknown Total dose per day: _____ ☐ Unknown O mg O mg/mL O mcg O other, specify _____ Start Date (of above dose) _____-_____-_____ mm-dd-yyyy
3	O MRI O CT O Other imaging, specify _____	_____-_____-_____ mm-dd-yyyy ☐ Unknown	O No O Unknown O Yes, name _____ ☐ Unknown Total dose per day: _____ ☐ Unknown O mg O mg/mL O mcg O other, specify _____ Start Date (of above dose) _____-_____-_____ mm-dd-yyyy
4	O MRI O CT O Other imaging, specify _____	_____-_____-_____ mm-dd-yyyy ☐ Unknown	O No O Unknown O Yes, name _____ ☐ Unknown Total dose per day: _____ ☐ Unknown O mg O mg/mL O mcg O other, specify _____ Start Date (of above dose) _____-_____-_____ mm-dd-yyyy

*****Important: If there are additional records to report, list on supplemental AI form. *****

AI

ACRIN 6684
Assessment of Tumor Hypoxia in Glioblastoma using FMISO
Supplemental Additional Imaging

If this is a revised or corrected form, please √box. ☐

ACRIN Study 6684
PLACE LABEL HERE
Institution ____________ **Institution No.** ____________
Participant Initials ____________ **Case No.** ____________

Sequence # [1]	Type of Imaging [2] specify [3]	Date of Imaging [4] Unknown [5]	Was the participant taking any steroids at the time of the Imaging? [6] Steroid name [7] Steroid name unknown [15] Steroid dose [8] Dose unknown [9] Dose units [10] Units, other specify [11] Start Date: Month [12] - Day [13] - Year [14] Record '99' if unknown
__|__	O MRI O CT O Other imaging, specify __________	___-___-___ mm-dd-yyyy ☐ Unknown	O No O Unknown O Yes, name __________ ☐ Unknown Total dose per day: ____ ☐ Unknown O mg O mg/mL O mcg O other, specify ______ Start Date (of above dose) ___-___-___ mm-dd-yyyy
__|__	O MRI O CT O Other imaging, specify __________	___-___-___ mm-dd-yyyy ☐ Unknown	O No O Unknown O Yes, name __________ ☐ Unknown Total dose per day: ____ ☐ Unknown O mg O mg/mL O mcg O other, specify ______ Start Date (of above dose) ___-___-___ mm-dd-yyyy
__|__	O MRI O CT O Other imaging, specify __________	___-___-___ mm-dd-yyyy ☐ Unknown	O No O Unknown O Yes, name __________ ☐ Unknown Total dose per day: ____ ☐ Unknown O mg O mg/mL O mcg O other, specify ______ Start Date (of above dose) ___-___-___ mm-dd-yyyy
__|__	O MRI O CT O Other imaging, specify __________	___-___-___ mm-dd-yyyy ☐ Unknown	O No O Unknown O Yes, name __________ ☐ Unknown Total dose per day: ____ ☐ Unknown O mg O mg/mL O mcg O other, specify ______ Start Date (of above dose) ___-___-___ mm-dd-yyyy

*****Important: If there are additional records to report, list on supplemental AI form. *****

AT

ACRIN 6684
Tumor Hypoxia in Glioblastoma using FMISO
Additional Treatment Form

If this is a revised or corrected form, please √box. ☐

ACRIN Study Case #

PLACE LABEL HERE

Institution _____ Institution No. _____

Participant Initials _____ Case No. _____

Sequence # [1]	Treatment Type Specify [3] [2]	Treatment Description [4] / Treatment Name [16]	Dose Not Applicable/Unknown [5] Dose [6] Dose Units [7] Units Specify [8]	Start Date Month [9] - Day [10] - Year [11]	Stop Date Month [12] - Day [13] - Year [14] ☐ Ongoing [15]	Any interruptions? [17]
1	O Chemotherapy, O Radiation O Surgery O Anti-VEGF agent O PARP inhibitor O Other, specify _____	**Chemo:** O TMZ O other, describe below **Anti-VEGF agent:** O Bevacizumab O Aflibercept O Vatalanib O XL184 O Blinded clinical trial O Other, describe below **PARP Inhibitor:** O BSI O ABT-888 O Other, describe below **Radiation:** O IMRT O other, describe below **Surgery:** Describe below **Description:** _____	☐ Not Applicable/Unknown _____ Dose Check Units: O mg O mg/kg O mg/m² O mcg O Other _____	____-____-____ *(mm-dd-yyyy)*	____-____-____ *(mm-dd-yyyy)* ☐ Ongoing	O No O Yes, complete T4 form
2	O Chemotherapy, O Radiation O Surgery O Anti-VEGF agent O PARP inhibitor O Other, specify _____	**Chemo:** O TMZ O other, describe below **Anti-VEGF agent:** O Bevacizumab O Aflibercept O Vatalanib O XL184 O Blinded clinical trial O Other, describe below **PARP Inhibitor:** O BSI O ABT-888 O Other, describe below **Radiation:** O IMRT O other, describe below **Surgery:** Describe below **Description:** _____	☐ Not Applicable/Unknown _____ Dose Check Units: O mg O mg/kg O mg/m² O mcg O Other _____	____-____-____ *(mm-dd-yyyy)*	____-____-____ *(mm-dd-yyyy)* ☐ Ongoing	O No O Yes, complete T4 form
3	O Chemotherapy, O Radiation O Surgery O Anti-VEGF agent O PARP inhibitor O Other, specify _____	**Chemo:** O TMZ O other, describe below **Anti-VEGF agent:** O Bevacizumab O Aflibercept O Vatalanib O XL184 O Blinded clinical trial O Other, describe below **PARP Inhibitor:** O BSI O ABT-888 O Other, describe below **Radiation:** O IMRT O other, describe below **Surgery:** Describe below **Description:** _____	☐ Not Applicable/Unknown _____ Dose Check Units: O mg O mg/kg O mg/m² O mcg O Other _____	____-____-____ *(mm-dd-yyyy)*	____-____-____ *(mm-dd-yyyy)* ☐ Ongoing	O No O Yes, complete T4 form

*****Important: If there are additional records to report, list on supplemental AT form. *****

AT

ACRIN 6684
Tumor Hypoxia in Glioblastoma using FMISO
Supplemental Additional Treatment Form

If this is a revised or corrected form, please √box. ☐

ACRIN Study Case #

PLACE LABEL HERE

Institution _____ Institution No. _____

Participant Initials _____ Case No. _____

Sequence # [1]	Treatment Type Specify [3] [2]	Treatment Description [4] Treatment Name [16]	Dose Not Applicable/Unknown [5] Dose [6] Dose Units [7] Units Specify [8]	Start Date Month - Day - Year [9] [10] [11]	Stop Date Month - Day - Year [12] [13] [14] ☐ Ongoing [15]	Any interruptions? [17]
1	O Chemotherapy, O Radiation O Surgery O Anti-VEGF agent O PARP inhibitor O Other, specify _____	**Chemo**: O TMZ; O other, describe below **Anti-VEGF agent**: O Bevacizumab; O Aflibercept; O Vatalanib; O XL184; O Blinded clinical trial; O Other, describe below **PARP Inhibitor**: O BSI; O ABT-888; O Other, describe below **Radiation**: O IMRT; O other, describe below **Surgery**: Describe below **Description:** _____	☐ Not Applicable/Unknown _____ Dose Check Units: O mg; O mg/kg; O mg/m²; O mcg; O Other _____	____-____-____ *(mm-dd-yyyy)*	____-____-____ *(mm-dd-yyyy)* ☐ Ongoing	O No O Yes, complete T4 form
2	O Chemotherapy, O Radiation O Surgery O Anti-VEGF agent O PARP inhibitor O Other, specify _____	**Chemo**: O TMZ; O other, describe below **Anti-VEGF agent**: O Bevacizumab; O Aflibercept; O Vatalanib; O XL184; O Blinded clinical trial; O Other, describe below **PARP Inhibitor**: O BSI; O ABT-888; O Other, describe below **Radiation**: O IMRT; O other, describe below **Surgery**: Describe below **Description:** _____	☐ Not Applicable/Unknown _____ Dose Check Units: O mg; O mg/kg; O mg/m²; O mcg; O Other _____	____-____-____ *(mm-dd-yyyy)*	____-____-____ *(mm-dd-yyyy)* ☐ Ongoing	O No O Yes, complete T4 form
3	O Chemotherapy, O Radiation O Surgery O Anti-VEGF agent O PARP inhibitor O Other, specify _____	**Chemo**: O TMZ; O other, describe below **Anti-VEGF agent**: O Bevacizumab; O Aflibercept; O Vatalanib; O XL184; O Blinded clinical trial; O Other, describe below **PARP Inhibitor**: O BSI; O ABT-888; O Other, describe below **Radiation**: O IMRT; O other, describe below **Surgery**: Describe below **Description:** _____	☐ Not Applicable/Unknown _____ Dose Check Units: O mg; O mg/kg; O mg/m²; O mcg; O Other _____	____-____-____ *(mm-dd-yyyy)*	____-____-____ *(mm-dd-yyyy)* ☐ Ongoing	O No O Yes, complete T4 form

*****Important: If there are additional records to report, list on supplemental AT form. *****

T4

ACRIN 6684

Assessment of Tumor Hypoxia in Glioblastoma using FMISO
Protocol Treatment Interruptions

If this is a revised or corrected form, please √box. ☐

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

Sequence # [1]	Protocol Specified Treatment [2] 1 Temozolomide 2 Radiation 3 Anti-VEGF agent 4 PARP inhibitor	Start Date of Interruption *(mm-dd-yyyy)* [3] [4] [5] Record '99' if unknown	Stop Date of Interruption *(mm-dd-yyyy)* [6] [7] [8] ☐ ongoing [9] Record '99' if unknown	Primary Reason for Modification [10] 1 Toxicity 2 Disease Progression 3 Scheduling Problems 4 Participant Decision 5 PCP decision 6 Other complicating disease 7 Alternative therapy 99 Unknown	Type of Modification [11] 1 Dose Held 2 Dose Reduced 3 Dose Missed	Reduced Dose Given skip if dose held/missed Dose [12] Unit [13] _____ [14]
1.	Code: _____	____-____-____	____-____-____ ☐ ongoing	Code: _____	Code: _____	_____ O mg O mg/m² O other: _____
2.	Code: _____	____-____-____	____-____-____ ☐ ongoing	Code: _____	Code: _____	_____ O mg O mg/m² O other: _____
3.	Code: _____	____-____-____	____-____-____ ☐ ongoing	Code: _____	Code: _____	_____ O mg O mg/m² O other: _____
4.	Code: _____	____-____-____	____-____-____ ☐ ongoing	Code: _____	Code: _____	_____ O mg O mg/m² O other: _____
5.	Code: _____	____-____-____	____-____-____ ☐ ongoing	Code: _____	Code: _____	_____ O mg O mg/m² O other: _____
6.	Code: _____	____-____-____	____-____-____ ☐ ongoing	Code: _____	Code: _____	_____ O mg O mg/m² O other: _____
7.	Code: _____	____-____-____	____-____-____ ☐ ongoing	Code: _____	Code: _____	_____ O mg O mg/m² O other: _____
8.	Code: _____	____-____-____	____-____-____ ☐ ongoing	Code: _____	Code: _____	_____ O mg O mg/m² O other: _____
9.	Code: _____	____-____-____	____-____-____ ☐ ongoing	Code: _____	Code: _____	_____ O mg O mg/m² O other: _____
10.	Code: _____	____-____-____	____-____-____ ☐ ongoing	Code: _____	Code: _____	_____ O mg O mg/m² O other: _____

*****Important: If there are additional interruptions to report, use supplemental T4 form. *****

T4

ACRIN 6684

Assessment of Tumor Hypoxia in Glioblastoma using FMISO

Supplemental Protocol Treatment Interruptions

If this is a revised or corrected form, please √ box. ☐

ACRIN Study 6684

PLACE LABEL HERE

Institution ______________ Institution No. ______________

Participant Initials ______________ Case No. ______________

Sequence # [1]	Protocol Specified Treatment [2] 1 Temozolomide 2 Radiation 3 Anti-VEGF agent 4 PARP inhibitor	Start Date of Interruption *(mm-dd-yyyy)* [3] [4] [5] Record '99' if unknown	Stop Date of Interruption *(mm-dd-yyyy)* [6] [7] [8] ☐ ongoing [9] Record '99' if unknown	Primary Reason for Modification [10] 1 Toxicity 2 Disease Progression 3 Scheduling Problems 4 Participant Decision 5 PCP decision 6 Other complicating disease 7 Alternative therapy 99 Unknown	Type of Modification [11] 1 Dose Held 2 Dose Reduced 3 Dose Missed	Reduced Dose Given skip if dose held/missed Dose [12] Unit [13] ______ [14]
☐	Code: ______	____-____-______	____-____-______ ☐ ongoing	Code: ______	Code: ______	______ O mg O mg/m² O other: ______
☐	Code: ______	____-____-______	____-____-______ ☐ ongoing	Code: ______	Code: ______	______ O mg O mg/m² O other: ______
☐	Code: ______	____-____-______	____-____-______ ☐ ongoing	Code: ______	Code: ______	______ O mg O mg/m² O other: ______
☐	Code: ______	____-____-______	____-____-______ ☐ ongoing	Code: ______	Code: ______	______ O mg O mg/m² O other: ______
☐	Code: ______	____-____-______	____-____-______ ☐ ongoing	Code: ______	Code: ______	______ O mg O mg/m² O other: ______
☐	Code: ______	____-____-______	____-____-______ ☐ ongoing	Code: ______	Code: ______	______ O mg O mg/m² O other: ______
☐	Code: ______	____-____-______	____-____-______ ☐ ongoing	Code: ______	Code: ______	______ O mg O mg/m² O other: ______
☐	Code: ______	____-____-______	____-____-______ ☐ ongoing	Code: ______	Code: ______	______ O mg O mg/m² O other: ______
☐	Code: ______	____-____-______	____-____-______ ☐ ongoing	Code: ______	Code: ______	______ O mg O mg/m² O other: ______
☐	Code: ______	____-____-______	____-____-______ ☐ ongoing	Code: ______	Code: ______	______ O mg O mg/m² O other: ______

*****Important: If there are additional interruptions to report, use supplemental T4 form. *****

MH

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO
Supplemental Baseline Abnormalities

ACRIN Study **6684**

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

If this is a revised or corrected form, please √ box. ☐

SUPPLEMENTAL BASELINE ABNORMALITIES

NOTE: Do not record any prior cancer treatment/therapies on this form. Record all on the TX form.

Check "none" if there are no abnormalities to report

☐ None[1]

Sequence # [2]	Condition / Event [3]	Online CTCAE/MedDRA Term [4]	Grade (1 = Mild, 2 = Moderate, 3 = Severe, 4 = Life threatning or disabling, 99 = Unknown) [5]
1			O 1 O 2 O 3 O 4 O 99
2			O 1 O 2 O 3 O 4 O 99
3			O 1 O 2 O 3 O 4 O 99
4			O 1 O 2 O 3 O 4 O 99
5			O 1 O 2 O 3 O 4 O 99
6			O 1 O 2 O 3 O 4 O 99
7			O 1 O 2 O 3 O 4 O 99
8			O 1 O 2 O 3 O 4 O 99
9			O 1 O 2 O 3 O 4 O 99
10			O 1 O 2 O 3 O 4 O 99
11			O 1 O 2 O 3 O 4 O 99
12			O 1 O 2 O 3 O 4 O 99

*****Important: If there are additional records to report, list on Supplemental MH form.*****

CO

ACRIN 6684

Tumor Hypoxia in Glioblastoma using FMISO
Concomitant Medications

ACRIN Study 6684

PLACE LABEL HERE

Institution _____ **Institution No.** _____

Participant Initials _____ **Case No.** _____

If this is a revised or corrected form, please ✓ box. ☐

CONCOMITANT MEDICATIONS

☐ None[13] Check "none" if there are no Concomitant Medications to report.

# of medication being reported.[1]	**Medication**[2] (Generic Name only)	**Start date** (mm/dd/yyyy) [3] [4] [5] Record '99' if unknown	**End date** (mm/dd/yyyy) [7] [8] [9] Record '99' if unknown Ongoing[11]	**Indication**[12] (reasons for use)
1		____/____/_____	____/____/_____ ☐ Ongoing	
2		____/____/_____	____/____/_____ ☐ Ongoing	
3		____/____/_____	____/____/_____ ☐ Ongoing	
4		____/____/_____	____/____/_____ ☐ Ongoing	
5		____/____/_____	____/____/_____ ☐ Ongoing	
6		____/____/_____	____/____/_____ ☐ Ongoing	
7		____/____/_____	____/____/_____ ☐ Ongoing	
8		____/____/_____	____/____/_____ ☐ Ongoing	
9		____/____/_____	____/____/_____ ☐ Ongoing	
10		____/____/_____	____/____/_____ ☐ Ongoing	

*****List additional Concomitant Medications on Supplemental CO form.*****

CO

ACRIN 6684
Tumor Hypoxia in Glioblastoma using FMISO
Concomitant Medications, Supplemental Form

If this is a revised or corrected form, please √ box. ☐

ACRIN Study 6684
PLACE LABEL HERE
Institution ____________ **Institution No.** ____________
Participant Initials ____________ **Case No.** ____________

SUPPLEMENTAL CONCOMITANT MEDICATIONS

☐ None[13] Check "none" if there are no Concomitant Medications to report.

# of medication being reported.[1]	**Medication**[2] (Generic Name only)	**Start date** (mm/dd/yyyy) [3] [4] [5] Record '99' if unknown	**End date** (mm/dd/yyyy) [7] [8] [9] Record '99' if unknown Ongoing[11]	**Indication**[12] (reasons for use)
		___/___/_____	___/___/_____ ☐ Ongoing	
		___/___/_____	___/___/_____ ☐ Ongoing	
		___/___/_____	___/___/_____ ☐ Ongoing	
		___/___/_____	___/___/_____ ☐ Ongoing	
		___/___/_____	___/___/_____ ☐ Ongoing	
		___/___/_____	___/___/_____ ☐ Ongoing	
		___/___/_____	___/___/_____ ☐ Ongoing	
		___/___/_____	___/___/_____ ☐ Ongoing	
		___/___/_____	___/___/_____ ☐ Ongoing	
		___/___/_____	___/___/_____ ☐ Ongoing	

*****List additional Concomitant Medications on Supplemental CO form.*****

ACRIN – 6684 FORM COMPLETION INSTRUCTIONS

Concomitant Medications Form

CO Completion Instructions

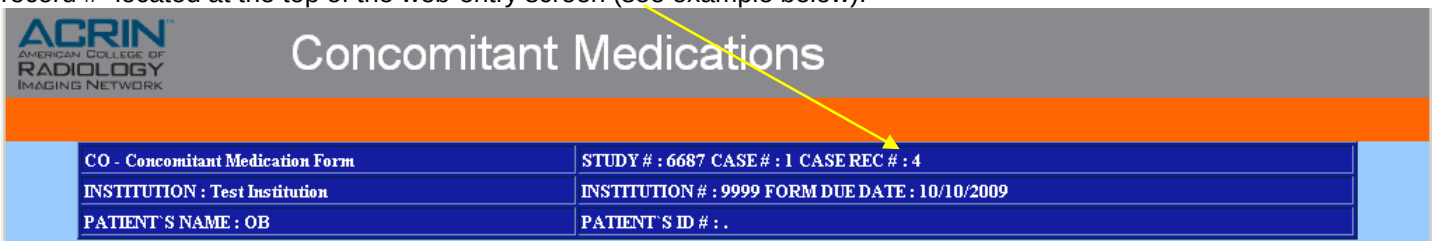
Additional form completion instructions can be found in the general form instructions document available on the ACRIN 6684website.

The CO form is required in the event the participant has an adverse event. All medications the participant took within 2 weeks prior to the adverse event must be recorded on the CO form. In the event there are >10 medications to report, please use the supplemental CO form.

Do not record the TMZ or ,if applicable, the anti-VEGF agent on this form.

If there are no Concomitant Medications to record, check “None” at the top of the form.

Medication Column:
***** Important***** When web-entering data, make sure that the “# of medication being reported” is equal to the “case record #” located at the top of the web-entry screen (see example below).



Start Date Column:
If either the month (mm) or day (dd) are unknown, record “99”. If the year (yyyy) is unknown, record “9999”.
Examples: 12/99/2008 or 01/15/9999.

If the entire date is unknown it should be recorded as ‘99/99/9999’

End Date Column:
If either the month (mm) or day (dd) are unknown, record “99”. If the year (yyyy) is unknown, record “9999”.
Examples: 12/99/2008 or 01/15/9999.

Check the “Ongoing” box if the participant is currently taking the medication.

The CO form will always appear on the data collection screen, one for each adverse event form.

Some tips:
-Always note the case record # at the top of the web screen and confirm it corresponds to the medication number you are entering.
-If the participant does not have any medications to report, check the ‘none’ box only on the 1st case record. Do not enter any additional case records with the none box checked.
In the event the ‘none’ box was checked on a case record by mistake, do not enter the medication on another case record, please record the correct medication information on the entry confirmation and fax to ACRIN DM for revision.