Name Code	Center No.	Screening No.	Patient No.	Date Form Completed
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __/__ __/__ __ __ __
				Mo Day Year

FORM 01 - SCREENING

1. Gender: 1 Male 2 Female
2. Date of Birth: Mo __ __ Day __ __ Yr __ __ __ __
3. Of Hispanic Origin: 1 Yes 2 No
4. Race: 1 White
   2 African-American/Black
   3 Asian/Pacific Islander
   4 Native American
   5 Other, specify_____

NOTE: A *NO* response to *QUESTIONS 5-9*, or a *YES* response to *QUESTIONS 10-26*, makes patient *INELIGIBLE*.

1 = YES
2 = NO

A. INCLUSION CRITERIA

SUBJECT:

5. Is 18 years of age or older..... _____
6. Has current dependence on heroin, morphine, or hydromorphone according to DSM-IV criteria..... _____
7. Reports use of heroin (at least three bags per day), morphine, or hydromorphone, for at least 21 of the last 30 days..._____
8. Has urine toxicology screen positive for opiates AND negative for methadone at the time of screening..... _____
9. Has voluntarily given informed consent AND signed the informed consent document..... _____

B. EXCLUSION CRITERIA

SUBJECT:

10. Is female and refuses to use a medically acceptable form of birth control (listed in the protocol)..... _____
11. Is a pregnant or nursing female..... _____
12. Reports use of methadone, buprenorphine, or LAAM in the past 14 days..... _____

***NOTE: Please review Forms # 3, 4, 5, 6, 7, 8, 10, 11, 24, 25 to determine the answers to questions 13-22.**

13. Has a history of seizures, or has received anticonvulsant therapy during the past 5 years.. ..... _____
14. Has pancreatic disease (such as insulin-dependent diabetes)..... _____
15. Has liver disease requiring medication or medical treatment, and/or AST or ALT levels greater than 5X the upper limit of normal..... _____
16. Has gastrointestinal or renal disease which would significantly impair absorption, metabolism or excretion of study drug, or require medication or medical treatment..... _____

Name Code	Center No.	Screening No.	Patient No.	Date Form Completed __
__ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __/__ __/__ __ __ __

Mo Day Year

1= YES

EXCLUSION CRITERIA (CONTINUED) **2= NO**

SUBJECT:

17. Has any neurological or psychiatric disorder (assessed by SCID) including psychosis, bipolar disorder, organic brain disease or other disorders which require treatment or which could make study compliance difficult. _____
18. Has active tuberculosis _____
19. Has an abnormal baseline cardiovascular exam including any clinically significant abnormal ECG (e.g., second or third degree heart block, uncontrolled arrhythmia), heart rate ≤ 45 bpm or symptomatic bradycardia, systolic blood pressure ≤ 90 mmHg or symptomatic hypotension, unmedicated BP ≥ 160/100 or a prior history of significant myocardial infarction. _____
20. Requires any of the following medications: psychotropics (including sedative/hypnotics, antidepressants, neuroleptics), prescription analgesics, anticonvulsants, antihypertensives, antiarrhythmics, antiretroviral medications (current or within the past 4 weeks) _____
21. Has current dependence (by DSM-IV criteria) on any psychoactive substance requiring detoxification other than heroin, morphine, hydromorphone, cocaine, caffeine, or nicotine _____
22. Is symptomatic for AIDS and has a CD4 counts ≤ 200 _____
23. Has donated blood within the last 8 weeks _____
24. Has participated in an investigational drug study within the past 3 months _____
25. Has such "poor" veins that even single venipunctures cannot be obtained in the beginning of the protocol _____
26. Became oversedated from the first dose of morphine sulfate 25 mg s.c. on Study Day 1 (i.e. nodding within 1 hour after dose) _____

C. ENROLLMENT STATUS

SUBJECT:

27. Signed informed consent and was entered into study: Mo__ __Day__ __Yr__ __ __ __
28. Was randomized into the Lofexidine or Placebo phase? 1 Yes_____ 2 No_____

A. If not randomized, please check reason below and complete end of study Form 31

1._____ Failed to meet inclusion or exclusion criteria listed above.

2._____ Declined study participation (Specify):_____

_____

Name Code	Center No.	Screening No.	Patient No.	Date Form Completed __
__ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __/__ __/__ __ __ __
				Mo Day Year

ENROLLMENT STATUS (CONTINUED)

28. Continued:

3._____ Administrative Discharge (Specify):_____

_____

4._____ Death

5._____ Other (Specify)_____

_____

FORM COMPLETED BY _____ Date_____

PHYSICIAN'S SIGNATURE_____ Date_____

Name Code	Center No.	Screening No	Patient No.	Assessment Date
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __ / __ __ / __ __ __
				Mo Day Year

FORM 02 – OPIATE SCREENING

Part A - Participant

Instructions to Participants: Please check the box or boxes that most closely agree with your answer.

1. Did you use heroin, morphine, or hydromorphone during the past 30 days?
   1=Yes_____ 2=No_____

   A. If yes, which of these opiates did you use? Check all that apply.
      1.____ Heroin
      2.____ Morphine
      3.____ Hydromorphone

2. During the past 30 days, how did you administer one or more of the above opiates? Check all that apply.
   1._____intravenous (in the vein) injection
   2._____subcutaneous ("skin pop") injection
   3._____intramuscular ("in your muscle") injection
   4._____smoked
   5._____snorted
   6._____oral

3. How many days in the last 30 days have you used heroin, morphine, or hydromorphone? _____ days

4. If you use heroin, how many bags of heroin do you use each day on average? _____bags

5. If you use morphine, estimate the amount of morphine that you use each day.

   1. ____ 100 mg, 2. ____ 200 mg, 3. ____ 300 mg, 4. ____ 400 mg, 5. ____ 500 mg, 6. ____ 600 mg,
   7. ____ 700 mg, 8. ____ 800 mg, 9. ____ 900 mg, 10____ > 1 g

6. If you use hydromorphone, estimate the amount of hydromorphone that you use each day.

   1. ____ 1 mg, 2. ____ 2 mg, 3. ____ 3 mg, 4. ____4 mg, 5. ____ 5 mg, 6. ____ 6 mg, 7 ____ 7 mg,
   8. ____8 mg, 9. ____ 9 mg, 10. ____> 10 mg

Name Code	Center No.	Screening No.	Patient No.	Assessment Date
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __ / __ __ / __ __ __ __
				Mo Date Year

Part B – Investigator

Instructions to Investigators: Please answer Part B only. Check the box or boxes that most closely agree with your answer. See example in Instructions for Use of this form in the Operations Manual.

7. In the city where the subject resides, based upon the following formula, calculate the approximate per day heroin consumption (based upon current DEA estimates):

A._____# of bags per day X 100 mg heroin/bag X 74.5% purity = __ __ __ __.__ mg heroin per day (Phil)

B._____# of bags per day X 100 mg heroin/bag X 65.3% purity = __ __ __ __.__ mg heroin per day (NY)

C._____# of bags per day X 100 mg heroin/bag X 33.1% purity = __ __ __ __.__ mg heroin per day (LA)

8. Is the participant's estimated amount of self-administered **heroin** greater than **40 mg** per day?

A. Yes_____ Proceed with inclusion of participant in the study.

B. No_____ Do not include this participant in the study.

C. Not Applicable:_____ Participant is dependent upon another opiate. Reply to questions #09 & #10 .

9. Is the participant's estimated amount of self-administered **morphine** greater than **120 mg** per day?

A. Yes_____ Proceed with inclusion of participant in the study.

B. No_____ Do not include this participant in the study.

C. Not Applicable:_____ Participant is dependent upon another opiate. Reply to question # 10.

10. Is the participant's estimated amount of self-administered **hydromorphone** greater than **6 mg** per day?

A. Yes_____ Proceed with inclusion of participant in the study.

B. No_____ Do not include this participant in the study.

C. Not Applicable: _____ Participant is dependent upon another opiate.

11. Is the participant's estimated daily amount of a combination of heroin, morphine or hydromorphone equivalent to greater than the designated amount of any of the substances above? (E.g. 90 mg morphine plus 4 mg hydromorphone per day.)

A. Yes____Proceed with inclusion of participant in the study.

B. No_____Do not include this participant in the study.

C. Not Applicable: _____ Participant in not on a combination of drugs.

PHYSICIAN SIGNATURE_____ **Date**_____

VA/NIDA STUDY 1020

A Phase 3 Placebo-Controlled, Double-Blind Multi-Site Trial of Lofexidine for Opiate Withdrawal

Name Code	Center No.	Screening No.	Patient No.	Study Day	Assessment Date
Mo Day Yr		5	1		/ /

FORM 03 - MEDICAL HISTORY

Does patient have history of: 1=Yes, Excludes 2=Yes, does not exclude 3=No history of		**Explain or describe (Comment required if yes)**
1. Allergies, drug		
2. Allergies, other		
3. Sensitivity to study med		
4. HEENT Disorder		
5. Cardiovascular Disorder		
6. Renal Disorder		
7. Hepatic Disorder		
8. Pulmonary Disorder, asthma		
9. Pulmonary Disorder, other		
10. Gastrointestinal Disorder		
11. Musculoskeletal Disorder		
12. Neurologic Disorder		
13 Neuroleptic Malignant Syndrome		
14 Psychiatric Disorder		
15. Dermatologic Disorder		
16. Metabolic Disorder		
17. Hematologic Disorder		
18. Endocrine Disorder		
19. Genitourinary Disorder		
20. Reproductive Disorder		
21. Infectious Disease (incl. HIV status)		
22. Other _____		
23. Other _____		

CSP #1020 - FORM 03 - Page 2 of 2

Name Code	Center No.	Screening No.	Patient No.	Study Day	Assessment Date
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __ (Mo Day Year)

24. **Has patient had any major surgery**? 1___ Yes 2___ No

If Yes, List MAJOR SURGERIES below.

TYPE OF SURGERY	1. DATE OF SURGERY (Month/Day/Year)	2. IS SURGERY RELEVANT TO STUDY? Yes, Excludes	Yes, Does Not Exclude	No
A. _____	__ __ / __ __/__ __ __ __	____	____	____
B. _____	__ __ / __ __/ __ __ __ __	____	____	____
C. _____	__ __ / __ __/ __ __ __ __	____	____	____
D. _____	__ __ / __ __/ __ __ __ __	____	____	____
E. _____	__ __ / __ __/ __ __ __ __	____	____	____

SMOKING HISTORY

25. **Does patient smoke cigarettes now**? 1___ Yes 2___ No

If Yes: Average NUMBER of cigarettes/day ___ ___

26. **Has patient ever smoked cigarettes for at least one year?** 1___ Yes 2___ No

If Yes:

A. Total number of YEARS smoked ___ ___

B. Highest average NUMBER of cigarettes/day ___ ___

27. **Does patient use or has patient used other tobacco products?** 1___ Yes 2___ No

If Yes:	1. CIGAR	2. CHEW	3. SNUFF	4. PIPE
A. Currently using?	1__yes 2__no	1__yes 2__no	1__yes 2__no	1__yes 2__no
B. Average number uses per day:	__ __	__ __	__ __	__ __
C. Total number of years used:		__ __ years	__ __ years	__ __ years
__ __ years				
D. Highest average number uses per day?	__ __ __/day	__ __ __/day	__ __ __/day	__ __ __/day

FORM COMPLETED BY Date

PHYSICIAN's SIGNATURE Date

Name Code	Center No.	Screening No.	Patient No.	Study Day	Assessment Date
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __
					Mo Day Year

FORM 04 - PHYSICAL EXAM

1. Weight ___ ___ ___lbs

2. Height: ___ ___.___ inches (complete at screening only)

A.
RESULTS OF EXAM
1=Abnormal, excludes
2=Abnormal, does not exclude
3=Normal
4=Not done

B.
PROVIDE DETAILS ON EACH ABNORMALITY BELOW.

3. Oral (mouth) _____ _____
4. HEENT (incl. thyroid/neck) _____
   _____
5. Cardiovascular _____ _____
6. Pulmonary _____ _____
7. Abdomen (incl. liver, spleen) _____
   _____
8. Extremities (incl status of veins) _____
   _____
9. Skin _____ _____
10. Neuropsychiatric:
    A. Mental Status _____ _____
    B. Sensory/Motor _____ _____
11. Lymph Nodes _____ _____
12. Musculoskeletal _____ _____
13. General Appearance _____ _____
14. Other, specify_____ _____ _____
15. Other, specify_____ _____ _____
16. Other, specify_____ _____ _____
17. Other, specify_____ _____ _____

Name Code	Center No.	Screening No.	Patient No.	Study Day	Assessment Date
_ _ _ _	_ _ _	5_ _ _	1 _ _ _	_ _	_ _/_ _/_ _ _ _ (Mo Day Year)

18. Does the patient have any current/ongoing medical problems other than his/her addiction? 1___ Yes 2___ No

If Yes, list these problems below:

	NATURE OF PROBLEM	1. DATE OF ONSET (Mo/Day/Yr)	2. CURRENT SEVERITY 1=Mild 2=Moderate 3=Severe
A.	_____	_ _-_ _-_ _ _ _	_____
B.	_____	_ _-_ _-_ _ _ _	_____
C.	_____	_ _-_ _-_ _ _ _	_____
D.	_____	_ _-_ _-_ _ _ _	_____
E.	_____	_ _-_ _-_ _ _ _	_____
F.	_____	_ _-_ _-_ _ _ _	_____

FORM COMPLETED BY_____ Date _____

PHYSICIAN'S SIGNATURE_____ Date_____

VA/NIDA STUDY 1020

A Phase 3 Placebo-Controlled, Double-Blind Multi-Site Trial of Lofexidine for Opiate Withdrawal

Name Code	Center No.	Screening No.	Patient No.	Study Day	Assessment Date
_ _ _ _	_ _ _	_5_ _ _	_1 _ _ _	_ _	_ _/_ _/_ _ _ _
					Mo Day Year

FORM 05 - PRIOR MEDICATIONS

A. Has the patient taken any medications (prescription or over-the-counter) in the past 30 days? 1= Yes 2= No

If **YES**, complete below. Use generic names when possible. Use associated codes for route. Use associated abbreviations for units and frequency. Make a new entry when a dosage and/or frequency change occurs. Record the way the patient actually took medication.

GENERIC NAME OF MEDICATION	**ROUTE**	**DOSE/UNIT**	**FREQUENCY**	**INDICATION** **List purpose for which medication is taken.**	**Medication Start Date (*Mo/Day/Yr)***	**Medication End Date (*Mo/Day/Yr)***	***circle "c" if continuing***
1.	_ _	/	_____		_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _	c
2.	_ _	/	_____		_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _	c
3.	_ _	/	_____		_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _	c
4.	_ _	/	_____		_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _	c
5.	_ _	/	_____		_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _	c
6.	_ _	/	_____		_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _	c
7.	_ _	/	_____		_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _	c
8.	_ _	/	_____		_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _	c

FORM COMPLETED BY _____ Date_____

PHYSICIAN'S SIGNATURE _____ Date _____

Name Code	Center No.	Screening No.	Patient No.	Study Day	Date Specimen Drawn
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __
					Mo Day Year

FORM 06 - HEMATOLOGY

1. Time specimen drawn ___ ___ ___ ___

CBC	**A.Value**	**B. Evaluation:** 1=Abnormal, excludes 2=Abnormal, does not exclude 3=Normal 9=Not done	**C. Comments** - Provide comments for any abnormal value.
2. Hemoglobin (g/dL)	___ ___ . ___	_____	
3. Hematocrit (%)	___ ___ . ___	_____	
4. RBC (M/mm^3)^	___ ___ . ___	_____	
5. Platelet count (K/mm^3)^^	___ ___ ___	_____	
6. WBC (K/mm^3)^^	___ ___ . ___	_____	
7. Neutrophils (%)	___ ___ . ___	_____	
8. Lymphocytes (%)	___ ___ . ___	_____	
9. Monocytes (%)	___ ___ . ___	_____	
10. Eosinophils (%)	___ ___ . ___	_____	
11. Basophils (%)	___ ___ . ___	_____	
12. Prothrombin Time (PT)	___ ___ . ___ **sec.**	_____	
13. Partial Thromboplastin Time (PTT)	___ ___ **sec.**	_____	

^Equivalent units: mil/cumm; mill/mcl; M/cmm; M/uL; X10*6/cumm

^^Equivalent units: thou/cumm; thou/mcl; K/cmm; 1000/uL; x10*3/cumm

FORM COMPLETED BY _____ Date _____

PHYSICIAN'S SIGNATURE _____ Date _____

Name Code	Center No.	Screening No.	Patient No.	Study Day	Date Specimen Drawn
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __
					Mo Day Year

FORM 07 - CHEMISTRY

1. Time specimen drawn: ___ ___ ___ ___

BLOOD CHEMISTRY	**A.Value**	**B. Evaluation:** 1=Abnormal, excludes 2=Abnormal, doesn't exclude 3=Normal 9=Not done	**C. Comments** - Provide comments for any abnormal value.
2. Sodium (mEq/L)^	___ ___ ___	_____	
3. Potassium (mEq/L)^	___ . ___	_____	
4. Chloride (mEq/L)^	___ ___ ___	_____	
5. CO2 (mEq/L)^	___ ___	_____	
6. Glucose (mg/dL)	___ ___ ___	_____	
7. Creatinine (mg/dL)	___ . ___	_____	
8. Albumin (g/dL)	___ ___ . ___	_____	
9. Total protein (g/dL)	___ ___ . ___	_____	
10. Calcium (mg/dL)	___ ___ . ___	_____	
11. Phosphorus (mg/dL)	___ ___ . ___	_____	
12. SGOT/AST (U/L)	___ ___ ___ ___	_____	
13. SGPT/ALT (U/L)	___ ___ ___ ___	_____	
14. GGT (U/L)	___ ___ ___ ___	_____	
15. Total bilirubin (mg/dL)	___ ___ . ___	_____	
16. LDH (U/L)	___ ___ ___	_____	
17. Alkaline phosphatase (U/L)	___ ___ ___	_____	
18. BUN (mg/dL)	___ ___ ___	_____	
19. Uric acid (mg/dL)^^	___ ___ . ___	_____	
20. Magnesium	___ ___ ___ ___ . ___	_____	
21. TSH	___ ___ ___ ___	_____	
22. Free T4	___ ___ ___ ___	_____	
23. Other_____	_____		

^ Equivalent unit: mmol/L ^^ Equivalent unit: ug/DL V.1/30/01

FORM COMPLETED BY _____ Date _____

PHYSICIAN'S SIGNATURE _____ Date _____

VA/NIDA STUDY 1020

A Phase 3 Placebo-Controlled, Double-Blind Multi-Site Trial of Lofexidine for Opiate Withdrawal

Name Code	Center No.	Screening No.	Patient No.	Study Day	Date Specimen Collected
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __
				Mo Day	Year

FORM 8 - URINALYSIS

1. Time specimen collected: ___ ___ ___ ___

URINALYSIS	**A.Value**	**B. Evaluation** 1=Abnormal, excludes 2=Abnormal, does not exclude 3=Normal 9=Not done	**C. Comments** - Provide comments for any abnormal value.
2. Specific gravity	___ . ___ ___ ___	_____	
3. pH	___ ___ . ___	_____	
4. Bilirubin	**___Neg ___Trace ___Present**	_____	
5. Nitrites	**___Neg ___Trace ___Present**	_____	
6. Urobilinogen	**___Neg ___Trace ___Present**	_____	
7. Glucose	**___Neg ___Trace ___Present**	_____	
8. Protein	**___Neg ___Trace ___Present**	_____	
9. Ketones	**___Absent ___Trace ___Present**	_____	
10. Occult Blood	**___Absent ___Trace ___Present**	_____	
Categories to rate the following measures (check one):	**None Few (1-5) Mod (6-10) Heavy (>10)**		
11. WBC	___ ___ ___ ___	_____	
12. RBC	___ ___ ___ ___	_____	
13. Epithelial Cells	___ ___ ___ ___	_____	

FORM COMPLETED BY _____ Date _____

PHYSICIAN'S SIGNATURE _____ Date _____

Name Code	Center No.	Screening No.	Patient No.	Study Day	Date Form Completed
_ _ _ _	_ _ _	_5_ _ _	_1 _ _ _	_ _	_ _/_ _/_ _ _ _ (Mo Day Year)

FORM 09 - BIRTH CONTROL/PREGNANCY ASSESSMENT

1. What method of birth control is participant currently using? _ _

   01 = Oral contraceptive
   02 = Barrier (diaphragm or condom plus spermicide)
   03 = Levonorgestrel implant (Norplant)
   04 = Intrauterine Progesterone Contraceptive system (IUD)
   05 = Medroxyprogesterone Acetate Contraceptive injection (Depo-Provera)
   06 = Complete abstinence
   07 = Hysterectomy Record date of procedure: Mo _ _ Yr _ _ _ _
   08 = Tubal Ligation Record date of procedure: Mo _ _ Yr _ _ _ _
   09 = Post-menopausal Record date of last menstrual period: Mo _ _ Yr _ _ _ _ 10 = Other, specify _____
   11 = None, specify _____

2. Result of serum pregnancy test 1___ Positive 2___ Negative

   A. Date Blood Specimen Collected Mo _ _ Day _ _ Yr _ _ _ _

FORM COMPLETED BY Date

PHYSICIAN'S SIGNATURE Date

Name Code	Center No.	Screening No.	Patient No.	Sudy Day	Date Form Completed
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __
					Mo Date Year

FORM 10 - INFECTIOUS DISEASE ASSESSMENT

	A. VALUE 1=Positive 2=Negative 3=Indeterminate	B. EVALUATION 1=abnormal, excludes 2=abnormal, does not exclude 3=normal 9=not done	C. COMMENTS Provide comments for any abnormal value.	D. DATE BLOOD DRAWN
1. Hepatitis B Surface Antigen (Hbs Ag)	_____	_____	_____	Mo___ ___Day___ ___Yr___ ___ ___ ___
2. Hepatitis B Surface Antibody (Anti-HBs)	_____	_____	_____	
3. Hepatitis B Core Antibody (Anti-HBc)	_____	_____	_____	
4. Hepatitis C Virus Antibody (HCV Ab)	_____	_____	_____	

5. **PPD**:

A. Date of PPD test: Mo ___ ___ Day ___ ___ Yr ___ ___ ___ ___

B. Date PPD read: Mo ___ ___ Day ___ ___ Yr ___ ___ ___ ___

C. Result of PPD test: _____ Positive _____Negative _____Indeterminate

D. If PPD not done, reason: 1 ☐ Already Positive 2 ☐ Other, Specify_____

<u>If past or current PPD is positive, a chest x-ray is required.</u>

E. Date of chest x-ray: Mo ___ ___ Day ___ ___ Yr ___ ___ ___ ___

F. Chest x-ray result: 1 ____ Normal 2____ Abnormal, does not exclude 3____ Abnormal, excludes from study entry

6. **RPR**: 1 _____Reactive 2 _____ Nonreactive Date Blood Drawn - Mo___ ___Day___ ___Yr___ ___ ___ ___

7. **CD4**: ___ ___ ___ ___ Date Blood Drawn - Mo___ ___Day___ ___Yr___ ___ ___ ___ Not Done_____

FORM COMPLETED BY Date

PHYSICIAN'S SIGNATURE Date Form VA 10-21044(NR)j - August 2000 v.1/30/01

Name Code	Center No.	Screening No	Patient No.	Study Day	Assessment Date
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __
					Mo Day Year

FORM 11 - STRUCTURED CLINICAL INTERVIEW (SCID)

I. SUMMARY OF SCID-I INTERVIEW (Diagnosis codes are listed on next page)

A. AXIS I –Substance Abuse/Dependence Disorders

1. Does the participant currently meet DSM-IV criteria for opiate dependence?1=Yes☐2=No ☐

2. Please list any other substance abuse/dependence disorders for which the participant **currently** meets criteria. **If none, code a. as 000.**

   a.☐☐☐ b.☐☐☐ c. ☐☐☐ d. ☐☐☐

3. Please list any other substance abuse/dependence disorders for which the participant has a **lifetime** history but does not currently meet criteria. **If none code a. as 000.**

   a. ☐☐☐ b. ☐☐☐ c. ☐☐☐ d. ☐☐☐

B. AXIS I- Non-substance Abuse/Dependence Disorders

1. Please list any non-substance abuse/dependence disorders for which the participant **currently** meets criteria. **If none, code a. as 00.**

   a. ☐☐ b. ☐☐ c. ☐☐ d. ☐☐

2. Please list any other non substance abuse/dependence disorders for which the participant has a **lifetime** history but does not currently meet criteria. **If none code a. as 00.**

   a. ☐☐ b. ☐☐ c. ☐☐ d. ☐☐

Form Completed By: _____ Date: _____

SCID-I DIAGNOSIS CODES

Part A: Codes for Axis-I Substance Abuse/Dependence Disorders (If none, code as 000)

17A	Alcohol Abuse	17D	Alcohol Dependence
18A	Sedative-Hypnotic-Anxiolytic Abuse	18D	Sedative-Hypnotic-Anxiolytic Dependence
19A	Cannabis Abuse	19D	Cannabis Dependence
20A	Stimulant Abuse	20D	Stimulant Dependence
21A	Opiod Abuse	21D	Opiod Dependence
22A	Cocaine Abuse	22D	Cocaine Dependence
23A	Hallucinogen/PCP Abuse	23D	Hallucinogen/PCP Dependence
24A	Poly-Drug Abuse	24D	Poly-Drug Dependence
25A	Other Abuse	25D	Other Dependence

Part B: Codes for Axis-I Non-Substance Abuse/Dependence Disorders (If none, code as 00)

01	Bipolar I Disorder	27	Agoraphobia without History of Panic Disorder
02	Bipolar II Disorder	28	Social Phobia
03	Other Bipolar Disorder	29	Specific Phobia
04	Major Depressive Disorder	30	Obsessive Compulsive
05	Dysthymic Disorder	31	Post-traumatic Stress
06	Depressive Disorder Not Otherwise Specified	32	Generalized Anxiety
07	Mood Disorder Due to a General Medical Condition	33	Anxiety Disorder due to a General Medical Condition
08	Substance-Induced Mood Disorder	34	Substance Induced Anxiety Disorder
09	Schizophrenia	35	Anxiety Disorder Not Otherwise Specified
10	Schizophreniform Disorder	36	Somatization Disorder
11	Schizoaffective Disorder	37	Pain Disorder
12	Delusional Disorder	38	Undifferentiated Somatoform Disorder
13	Brief Psychotic Disorder	39	Hypochondriasis
14	Psychotic Disorder Due to a General Medical Condition	40	Body Dysmorphic
15	Substance-Induced Psychotic Disorder	41	Anorexia Nervosa
16	Psychotic Disorder Not Otherwise Specified	42	Bulemia Nervosa
26	Panic Disorder	43	Binge Eating Disorder
		44	Adjustment Disorder

VA/NIDA STUDY 1020

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Name Code	Center No.	Screening No.	Patient No.	Study Day	Assessment Date
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __
					Mo Day Yr

Time Administered

__ __ __ __

FORM 13 - MODIFIED HIMMELSBACH OPIATE WITHDRAWAL SCALE (MHOWS)

INSTRUCTIONS: Observe the patient for a 10 (ten) minute period.

		NOT PRESENT	PRESENT
1.	Yawning	_____	_____
2.	Lacrimation	_____	_____
3.	Rhinorrhea (sniffs and nose touches)	_____	_____
4.	Perspiration	_____	_____
5.	Tremor (hands)	_____	_____
6.	Piloerection (Gooseflesh - observe patient's forearm)	_____	_____
7.	Restlessness (frequent shifts of position, fidgeting)	_____	_____

8. Appetite

Breakfast	__ Not Hungry	__ Minimal	__ Moderate	__ Excellent
Lunch	__ Not Hungry	__ Minimal	__ Moderate	__ Excellent
Dinner	__ Not Hungry	__ Minimal	__ Moderate	__ Excellent

9. Pupil __ __ . __ (mm) Circle Eye R L Pupil Photo Times: 1) Hr Min 2) Hr Min
__ __ __ __ __ __ __ __

10. Weight (lbs) __ __ __ . __

11. Temperature (F) __ __ __ . __

12. Vital Signs: Sitting: BP (mmHg) __ __ __ /__ __ __ HR(beats/min) __ __ __
Respirations (per min) __ __ __

13. Emesis: Record on Emesis Tracking Form #14

14. Temperature of room __ __ __ . __ºF

Form Completed by_____Date_____ v. 2/21/01

VA Form – 10-21044(NR)m – August 2000

VA/NIDA STUDY 1020

A Phase 3 Placebo-Controlled, Double-Blind Multi-Site Trial of Lofexidine for Opiate Withdrawal

Name Code	Center No.	Screening No.	Patient No.	Study Day	Emesis Occurrence
_ _ _ _	_ _ _	_5_ _ _	_1 _ _ _	_ _	_ _/_ _/_ _ _ _
					Mo Day Year

FORM 14 – EMESIS TRACKING FORM

Record below the time of each distinct episode of vomiting (separated by at least one minute). Do not count dry heaves or expectorated mucous. Subjects should be reminded to contact unit staff to observe vomitus before flushing.

Time Emesis Occurred	Witness Signature
1. _ _ _ _	
2. _ _ _ _	
3. _ _ _ _	
4. _ _ _ _	
5. _ _ _ _	
6. _ _ _ _	
7. _ _ _ _	
8. _ _ _ _	
9. _ _ _ _	
10. _ _ _ _	
11. _ _ _ _	
12. _ _ _ _	
13. _ _ _ _	
14. _ _ _ _	
15. _ _ _ _	
16. _ _ _ _	
17. _ _ _ _	
18. _ _ _ _	

If no emesis occurred 0000 – 2400, check here _____

FORM CHECKED BY _____Date_____

VA/NIDA STUDY 1020

A Phase 3 Placebo-Controlled, Double-Blind Multi-Site Trial of Lofexidine for Opiate Withdrawal

Name Code	Center No.	Screening No.	Patient No.	Study Day	Assessment Date
_ _ _ _	_ _ _	5_ _ _	1_ _ _	_ _	_ _ / _ _ / _ _ _ _
					Mo Day Year

Time Administered

_ _ _ _

FORM 15 - OBJECTIVE OPIATE WITHDRAWAL SCALE (OOWS-HANDLESMAN)

INSTRUCTIONS: Read each item below carefully and place an "X" in either the PRESENT or the NOT PRESENT column. Please answer each item. Observe the patient for a 10 (ten) minute period.

		NOT PRESENT	PRESENT
1.	Yawning (*one or more)*	____	_____
2.	Rhinorrhea (three or more= present)	____	_____ *(three or more)*
3.	Piloerection (Gooseflesh – observe patient's arm)	____	_____
4.	Perspiration	____	_____
5.	Lacrimation	____	_____
6.	Mydriasis	____	_____
7.	Tremors (hands)	____	_____
8.	Hot and cold flashes (Shivering or huddling for warmth)	____	_____
9.	Restlessness (Frequent shifts of position)	____	_____
10.	Vomiting	____	_____
11.	Muscle twitches	____	_____
12.	Abdominal cramps (Holding stomach)	____	_____
13.	Anxiety (Range: mild to severe)	____	_____ (***M***=*mild,* ***MD***=*mod)* (***S***=*severe*)

Mild**:** observable manifestations – foot shaking, fidgeting, finger tapping.

Moderate to severe**:** agitation, unable to sit, trembling, panicky; complains of difficulty in breathing, choking sensations, palpitations.

FORM COMPLETED BY_____DATE_____

VA/NIDA STUDY 1020

A Phase 3 Placebo-Controlled, Double-Blind Multi-Site Trial of Lofexidine for Opiate Withdrawal

Name Code Center No. Screening No. Patient No. Study Day Assessment Date Assessment Time

__ __ __ __ __ __ __ __5__ __ __ __1 __ __ __ __ __ __/__ __/__ __ __ __ __ __ __ __

Mo Day Year

FORM 16 - SHORT OPIATE WITHDRAWAL SCALE (SOWS, GOSSOP)

Please put a check mark in the appropriate box if you have suffered from any of the following conditions in the ***past 24 hours:***

	None	Mild	Moderate	Severe
1. Feeling Sick				
2. Stomach Cramps				
3. Muscle Spasms/Twitching				
4. Feeling of Coldness				
5. Heart Pounding				
6. Muscular Tension				
7. Aches and Pains				
8. Yawning				
9. Runny Eyes				
10. Insomnia/Problems Sleeping				

Name Code	Center No.	Screening No.	Patient No.	Study Day	Assessment Date
_ _ _ _	_ _ _	5_ _ _	1_ _ _	_ _	_ _ / _ _ / _ _ _ _
					Mo Day Year

_ _ _ _
Time Administered

FORM 17 - MODIFIED CLINICAL GLOBAL IMPRESSIONS – PATIENT VERSION

INSTRUCTIONS: Circle the most appropriate response listed underneath each question.

Question Number	MODIFIED CLINICAL GLOBAL IMPRESSIONS - PATIENT VERSION
1.	**SEVERITY OF OPIATE WITHDRAWAL** In your life as a person who has been addicted to opiates (e.g., heroin), how severe are your opiate withdrawal symptoms at this time? 1 = No opiate withdrawal symptoms 2 = On the border between no to mild opiate withdrawal symptoms 3 = Mild opiate withdrawal symptoms 4 = Moderate opiate withdrawal symptoms 5 = Marked opiate withdrawal symptoms 6 = Severe opiate withdrawal symptoms 7 = The most severe opiate withdrawal symptoms that I have ever had Maximum Score = 7
2.	**SIDE EFFECTS INDEX –** **Rate this item on the basis of THE STUDY DRUG THAT YOU ARE TAKING ONLY** **Select the response that best describes the degree of side effects that you are currently experiencing with the STUDY DRUG.** 1 = None. The study drug has no side effects 2 = The study drug has slight side effects, but it does NOT significantly interfere with my day to day activities on the unit 3 = The study drug has moderate side effects, and it DOES significantly interfere with my day to day activities on the unit 4 = The study drug has severe side effects, and these side effects are greater than the relief from opiate withdrawal symptoms that it provides Maximum Score = 4

(Adaptation of NIMH Clinical Global Impressions, Psychopharmacology Bulletin 21: 839-843, 1985; modified 072800, from 091499).

Name Code	Center No.	Screening No.	Patient No.	Study Day	Assessment Date
_ _ _ _	_ _ _	5_ _ _	1_ _ _	_ _	_ _ / _ _ / _ _ _ _
					Mo Day Year

_ _ _ _
Time Administered

FORM 18 – MODIFIED CLINICAL GLOBAL IMPRESSION – RATER VERSION -

INSTRUCTIONS: Circle the most appropriate response listed underneath each question.

Question Number	MODIFIED CLINICAL GLOBAL IMPRESSIONS - RATER VERSION
1.	**SEVERITY OF ILLNESS** **Considering your total clinical experience with this particular population, how ill (severity of opiate withdrawal symptoms) is the patient at this time?** 0 = Not at all ill 1 = Borderline ill 2 = Mildly ill 3 = Moderately ill 4 = Markedly ill 5 = Severely ill 6 = Among the most extremely ill patients Maximum Score = 6
2.	**SIDE EFFECTS INDEX –** **Rate this item on the basis of EFFECTS OF STUDY DRUG ONLY.** **Select the term which best describes the degree of side effects.** 1 = None, study drug is producing no side effects 2 = Do not significantly interfere with patient's functioning 3 = Significantly interferes with patient's functioning 4 = Outweighs therapeutic effect Maximum Score = 4

(Adaptation of NIMH Clinical Global Impressions, Psychopharmacology Bulletin 21: 839-843, 1985;modified 072800, from 091499).

Rater Signature_____Date_____

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A Phase 3 Placebo-Controlled, Double-Blind Multi-Site Trial of Lofexidine for Opiate Withdrawal

Name Code	Center No.	Screening No.	Patient No.	Study Day	Assessment Date
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __
				Mo Day	Year

Assessment Time

__ __ __ __

FORM 19 -SUBJECTIVE OPIATE WITHDRAWAL SCALE (SOWS, HANDELSMAN)

INSTRUCTIONS: Answer the following statements as accurately as you can. Rate the way you have been feeling the PAST 24 HOURS according to the scale below.

Please check the box which is the most appropriate for how you have been feeling.	**Not At All**	**A Little**	**Moderately**	**Quite A Bit**	**Extremely**
1. I have felt anxious.					
2. I have been yawning.					
3. I have been perspiring.					
4. My eyes have been tearing.					
5. My nose has been running.					
6. I have had gooseflesh.					
7. I have been shaking.					
8. I have had hot flashes.					
9. I have had cold flashes.					
10. My bones and muscles have been aching.					
11. I have been feeling restless.					
12. I have been feeling nauseous.					
13. I have felt like vomiting.					
14. My muscles have been twitching.					
15. I have had cramps in my stomach.					
16. I have felt like shooting up.					
17. I have had trouble sleeping.					
18. My appetite has been poor.					
19. I have had diarrhea.					

VA/NIDA STUDY 1020
A Phase 3 Placebo-Controlled, Double-Blind Multi-Site Trial of Lofexidine for Opiate Withdrawal

Name Code	Center No.	Screening No	Patient No.	Study Day	Assessment Date
_ _ _ _	_ _ _	_5_ _ _	_1 _ _ _	_ _	_ _/_ _/_ _ _ _
				Mo Day	Year

Assessment Time
_ _ _ _

FORM 20 - VAS-E (Sickness Alleviation)

Instructions: Draw a slash mark through the point on the line that best describes your opinion. (No photo copy of form will be accepted.)

1. How effective is study drug at relieving your withdrawal sickness?

length: _____ mm (staff use only)

Name Code Center No. Screening No Patient No. Study Day Date Medication Was Given

_ _ _ _ _ _ _ _ _ 5 _ _ _ _ 1 _ _ _ _ _ _ _/_ _/_ _ _ _

Mo Day Year

FORM 21 - MEDICATION ADMINISTRATION

Please use the approved medication codes on back to indicate the medication given. Record each dose of medication given in the 24 hour period from **0000 to 2400.** Specify only unlisted medications (code=14), and any deviations in dosage or route for any medication.

	Medication Number Code (01-14)	Medication Specify (Only required if medication code = 14)	Dosage/Units	Route	Time Med Given	Given for Opiate Withdrawal? (Circle One)
A.						
B.	_ _				_ _ _ _	Yes No
C.	_ _				_ _ _ _	Yes No
D.	_ _				_ _ _ _	Yes No
E.	_ _				_ _ _ _	Yes No
F.	_ _				_ _ _ _	Yes No
G.	_ _				_ _ _ _	Yes No
H.	_ _				_ _ _ _	Yes No
I.	_ _				_ _ _ _	Yes No
J.	_ _				_ _ _ _	Yes No
K.	_ _				_ _ _ _	Yes No
L.	_ _				_ _ _ _	Yes No
M.	_ _				_ _ _ _	Yes No
N.	_ _				_ _ _ _	Yes No
O.	_ _				_ _ _ _	Yes No
P.	_ _				_ _ _ _	Yes No
Q.	_ _				_ _ _ _	Yes No
R.	_ _				_ _ _ _	Yes No
S.	_ _				_ _ _ _	Yes No
T.	_ _				_ _ _ _	Yes No

FORM COMPLETED BY:_____Date_____

PHYSICIAN'S SIGNATURE:_____Date_____

APPROVED MEDICATION CODES
(SPECIFY route and dosage where different from below)

01 = Morphine s.c. (specify)

02 = Lofexidine/Placebo po (specify number of pills given)

03 = Multivitamin: 1 tab po qd at 0900

04 = Guaifenesen: 2 tsp po q2h PRN

05 = Maalox Plus (or generic alumina, magnesia & simethicare): 30cc po q4h PRN

06 = Colace (or generic dioctyl sodium sulfosuccinate): 100mg po q8h PRN

07 = Metamucil (or generic psyllium hydrocolloid suspension): 1 TBSP po q12h PRN

08 = Pepto Bismol: (or generic bismuth sulfate) 30cc po PRN (NTE 6 doses in 24 hrs)

09 = Tylenol: (or generic Acetaminophen) 650mg po q6h PRN
(NTE 4 doses in 24 hrs)

10 = Ambien: (or generic zolpidem) 10mg po PRN after 2300 - MRx1
before 0500. *(Record on AE Form 26)*

11 = Nicotine patch 21mg topically, once daily

12 = Nicotine patch 14mg topically, once daily

13 = Nicotine patch 7mg topically, once daily

14 = Other medication not listed above (must fill in SPECIFY)

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A Phase 3 Placebo-Controlled, Double-Blind Multi-Site Trial of Lofexidine for Opiate Withdrawal

Name Code	Center No.	Screening No.	Patient No.	Study Day	Assessment Date
_ _ _ _	_ _ _	_5_ _ _	_1 _ _ _	_ _ (Mo)	_ _/_ _/_ _ _ _ (Day / Year)

Assessment Time

_ _ _ _

FORM 22 - MORPHINE BENZEDRINE GROUP SCALE (ARCI MBG)

Instructions: For each item below, indicate how you are feeling <u>RIGHT NOW</u> by answering TRUE or FALSE.

	TRUE	FALSE
1. I would be happy all the time if I felt as I feel now.		
2. I am in the mood to talk about the feeling I have.		
3. I am full of energy.		
4. I would be happy all the time if I felt as I do now.		
5. Things around me seem more pleasing than usual.		
6. I feel less discouraged than usual.		
7. I fear that I will lose the contentment that I now have.		
8. I feel as if something pleasant just happened to me.		
9. Today I say things in the easiest possible way.		
10. I feel so good that I know other people can tell it.		
11. I feel more clear-headed than dreamy.		
12. I can completely appreciate what others are saying when I am in this mood.		
13. I feel as if I would be more popular with people today.		
14. I feel a very pleasant emptiness.		
15. I feel in complete harmony with the world and those about me.		
16. I have a pleasant feeling in my stomach.		
17. I feel high.		

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A Phase 3 Placebo-Controlled, Double-Blind Multi-Site Trial of Lofexidine for Opiate Withdrawal

Name Code	Center No.	Screening No.	Patient No.	Study Day	Assessment Date	
__ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __	__ __
					Mo Day Year	

Assessment Time

__ __ __ __

FORM 23 - VAS (HIGH)

Instructions: Draw a slash mark through the point on the line that best describes your opinion. (Photo copy of form will not be accepted.)

1. How "high" do you feel right now?

length: _____ mm (staff use only)

Name Code	Center No.	Patient No.	Study Day	Assessment Date	Assessment Time
_ _ _ _	_ _ _	_ _ _ _	_ _	_ _/_ _/_ _ _ _ (Month Day Year)	_ _ _ _

FORM 24 - VITAL SIGNS

COMPLETE A **NEW** FORM FOR **EACH** SESSION OF VITAL SIGNS TAKEN (FIVE TIMES DAILY). **If the patient exhibits any of the criteria below, copy the vital signs from this form onto Form 33. Then use Form 33 to track the patient's vital signs and associated interventions, per protocol, until the episode is resolved. Also initiate a Form 33 to track vital signs during an occurrence of Criteria B (symptoms) or C (medical interventions) below.**

Take sitting vital signs after patient has been **sitting** for 3 **minutes**. Then immediately stand the patient for 1 **minute** and take orthostatic **(standing)** vital signs.

Temperature (oral) F°	Type of Reading: Circle One	Not Done	BP Reading: Systolic/Diastolic	Heart Rate: Beats/min	Respiration: Breaths/min	Symptoms/Interventions
	*Lying or Sitting		/			
	*Sitting or Standing		/			

*If patient is too dizzy to stand, mark standing VS as Not Done. If patient is too dizzy to sit, record lying VS and mark standing VS as Not Done.

CRITERIA FOR INITIATING FORM 33 <u>VITAL SIGNS TRACKING:</u>

A. If the above **<u>vital signs</u>** meet any of the following criteria, either sitting or standing, initiate Form 33 and follow instructions. Also list the abnormal vital signs as an AE on **Form 26**.

1.) Systolic BP ≤ 80 mmHg
2.) Systolic BP >185 mmHg
3.) Diastolic BP >110mmHg
4.) Heart Rate <60 bpm **occurring with any of the symptoms below**

B. **<u>Symptoms</u>:** Initiate a Form 33 to track vital signs if patient experiences a single occurrence of any of the following, with or without abnormal vital signs:

1.) Symptoms of hypotension (dizziness, syncope) making it difficult to sit or stand for at least one minute
2.) Chest pain (clinically considered to be of possible cardiac origin, associated with ECG changes or cardiac enzymes)
3.) Clinically significant shortness of breath

4.) Decreased level of consciousness

C. **<u>Any medical intervention</u>:** Initiate Form 33, with or without abnormal vital signs, when any intervention (medication or non-medication) is used to treat any cardiac event.

D. Was a Vital Signs Tracking Form (Form 33) completed for the vital signs assessment above? 1= Yes____ 2= No____

PHYSICIAN'S SIGNATURE: _____ Date: _____

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A Phase 3 Placebo-Controlled, Double-Blind Multi-Site Trial of Lofexidine for Opiate Withdrawal

Name Code	Center No.	Screening No	Patient No.	Study Day	Date ECG Administered
_ _ _ _	_ _ _	_5_ _ _	_1_ _ _	_ _	_ _/_ _/_ _ _ _
					Mo Day Year

FORM 25 - ELECTROCARDIOGRAM RESULTS (ECG)

1. ECG overall results were ☐ Normal ☐ Abnormal
2. ***If ECG is abnormal, check all that apply below*:**

3. Increased QRS voltage	☐	P. Supraventricular tachycardia	☐
B. QT_c prolongation	☐	Q. Ventricular tachycardia	☐
4. Left ventricular hypertrophy	☐	R. 1st degree A-V block	☐
5. Right ventricular hypertrophy	☐	S. 2nd degree A-V block	☐
6. Acute infarction	☐	T. 3rd degree A-V block	☐
7. Subacute infarction	☐	U. Atrial Fibrillation	☐
8. Old infarction	☐	V. Atrial Flutter	☐
9. Myocardial ischemia	☐	W. Implanted Pacemaker	☐
10. Symmetrical t-wave inversions	☐	X. LBB Block	☐
11. Poor R-wave progression	☐	Y. RBB Block	☐
12. Other nonspecific ST/T	☐	Z. Pre-excitation Syndrome	☐
L. Sinus tachycardia	☐	Z1. Other Intraventricular Condition Block	☐
M. Sinus bradycardia	☐		
N. Supraventricular premature beat	☐	Z2. Other, Specify _____	☐
O. Ventricular premature beat	☐	Z3. Other, Specify _____	☐

3. Do any of the abnormalities preclude safe entry or continuation in the study? 1___Yes 2___No

   If Yes:

   A. list letter indicator(s) from Q.2. If more than 5 abnormalities, list the most severe: ___ ___ ___ ___ ___

4. Ventricular rate (bpm): ___ ___ ___
5. PR (ms): ___ ___ ___
6. QRS (ms): ___ ___ ___
7. QT_c (ms): ___ ___ ___
8. Read By:_____ Date Read - Mo__ __Day__ __Yr__ __ __ __
   (Please Print)

FORM COMPLETED BY Date

PHYSICIAN'S SIGNATURE Date

Name Code	Center No.	Screening No.	Patient No.	Study Day	Date of AE Occurrence
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __
					Mo Day Year

FORM 26 - ADVERSE EVENTS

COMPLETE THIS FORM DAILY BY AN MD OR NP. RECORD AEs FOR THE 24 HOUR PERIOD FROM 0000 TO 2400 . (An adverse event is any untoward medical occurrence experienced by a patient after study enrollment including a clinically significant laboratory test change from baseline.)

1. Has the patient experienced an adverse event from 0000 to 2400? 1=Yes ~**give details below:** 2=No ~

I. Relatedness:	II. Severity:	III. Action Taken:	IV. Outcome:
1=Definitely Study Drug Related 2=Probably Study Drug Related 3=Possibly Study Drug Related 4=Unrelated to Study Drug	1=Mild 2=Moderate 3=Severe ***4=Life Threatening**	1=None 2=Medication Prescribed 3=Medical Consultation 4=Study Drug Dose Withheld 5=Discontinued From Study	1=Resolved 2=Ongoing, Improving 3=Ongoing, No Change 4=Ongoing, Worsening ***5=Hospitalization** ***6=Death**

	Common Adverse Event Code From Box Below	SPECIFY Nature of Adverse Event (Only Required when Code =01)	Date of Onset *(Mo / Day / Yr)*	Time of Onset	I. Related - ness	II. Highest Level of Severity	III. Action Taken	IV. Outcome	If Resolved, Date of Resolution *(Mo / Day / Yr)* circle "c" if continuing	
A			__ __/__ __/__ __ __ __	__ __ __ __					__ __/__ __/__ __ __ __	c
B			__ __/__ __/__ __ __ __	__ __ __ __					__ __/__ __/__ __ __ __	c
C			__ __/__ __/__ __ __ __	__ __ __ __					__ __/__ __/__ __ __ __	c
D			__ __/__ __/__ __ __ __	__ __ __ __					__ __/__ __/__ __ __ __	c
E			__ __/__ __/__ __ __ __	__ __ __ __					__ __/__ __/__ __ __ __	c
F			__ __/__ __/__ __ __ __	__ __ __ __					__ __/__ __/__ __ __ __	c
G			__ __/__ __/__ __ __ __	__ __ __ __					__ __/__ __/__ __ __ __	c
H			__ __/__ __/__ __ __ __	__ __ __ __					__ __/__ __/__ __ __ __	c

*** Requires completion of Form 30 – Serious/Unexpected Adverse Event Form**

*Common Adverse Event Codes Please use codes to indicate the Adverse Event, and complete the remaining columns. Only use SPECIFY for code = 1 (other Adverse Event)

01=Other Adverse Event	07=Diarrhea	13=Gastric Upset	19=Muscle Aches	25=Rash	31=Vertigo
02=Abdominal Cramps	08=Dizziness	14=Headache	20=Nausea	26=Restlessness	32=Vomiting/
03=Anxiety	09=Drowsiness	15=Hypotension (<80 syst)	21=Nightmares	27=Rhinorrhea	Emesis
04=Appetite Decrease	10=Dry mouth, nose, throat	16=Insomnia	22=Numbness	28=Sweating	
05=Chest Pain	11=Fatigue	17=Joint Pain	23=Palpitations	29=Hypertension	

06=Constipation	12=Flushing	18=Lacrimation	24=Pruritis	30=Tremors

PHYSICIAN=S/NP SIGNATURE _____ Date _____

Name Code	Center No.	Screening No.	Patient No.	Study Day	Assessment Date
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __
Mo Day Year					

FORM 27 - TOBACCO WITHDRAWAL SYMPTOMS DAILY DIARY

1. Current time __ __ __ __

2. Please rate yourself on each of the following items using the categories provided. Mark the **one** box that best describes your feelings today.

	None	Slight	Mild	Moderate	Severe
A. Desire to smoke					
B. Anger, irritability, frustration					
C. Anxiety, nervousness					
D. Difficulty concentrating					
E. Impatience, restlessness					
F. Hunger					
G. Awakening at night					
H. Depression					

3. Have you smoked cigarettes today?

☐ No, none at all (not even one puff)

☐ Yes, one puff or more

A. If yes, how many **cigarettes** did you smoke today? ☐☐

4. Over the past 24 hours, how much of the time was one or more nicotine patches worn?

☐ Not at all

☐ Part of the time

☐ Entire time

VA/NIDA STUDY 1020

A Phase 3 Placebo-Controlled, Double-Blind Multi-Site Trial of Lofexidine for Opiate Withdrawal

Name Code	Center No.	Screening	Patient No.	Study Day	Date Specimen Collected
_ _ _ _	_ _ _	5	1 _ _ _	_ _	_ _/_ _/_ _ _ _
				Mo Day	Year

FORM 28 - URINE TOXICOLOGY

Urine temperature within expected range? 1=YES ☐ 2=NO ☐
(≥ 92°F or 33.3°C)

SCREEN FOR:

1.	AMPHETAMINES/METHAMPHETAMINES	1 Pos	2 Neg	3 Not Done	
2.	COCAINE METABOLITES	1 Pos	2 Neg	3 Not Done	
3.	BARBITURATES	1 Pos	2 Neg	3 Not Done	
4.	OPIATES	1 Pos	2 Neg	3 Not Done	
5.	BENZODIAZEPINES	1 Pos	2 Neg	3 Not Done	
6.	CANNABINOIDS (THC)	1 Pos	2 Neg	3 Not Done	
7.	METHADONE	1 Pos	2 Neg	3 Not Done	

FORM COMPLETED BY _____ Date _____

PHYSICIAN'S SIGNATURE_____ Date_____

Name Code	Center No.	Screening No	Patient No
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __

FORM 29 - PLASMA PK SAMPLING

Use this form to record plasma Pk blood draw. Fill in the date and actual time blood was drawn, check if it was drawn BEFORE study medication was administered, and sign.

Study Day	Time Draw Scheduled	Date Specimen Drawn Mo/Date/Year	Actual Time Blood Drawn	Was Blood Drawn BEFORE Study Med Given?	Signature of Person Obtaining Blood Draw
4	0800 (before Lofex dose)	__ __/__ __/__ __ __ __	__ __ __ __	____ YES ____ NO	
6	0800 (before Lofex dose)	__ __/__ __/__ __ __ __	__ __ __ __	____ YES ____ NO	
7	0800 (before Lofex dose)	__ __/__ __/__ __ __ __	__ __ __ __	____ YES ____ NO	
7	0900	__ __/__ __/__ __ __ __	__ __ __ __		
7	1000	__ __/__ __/__ __ __ __	__ __ __ __		
7	1100	__ __/__ __/__ __ __ __	__ __ __ __		
7	1200	__ __/__ __/__ __ __ __	__ __ __ __		
7	1300 (before Lofex dose)	__ __/__ __/__ __ __ __	__ __ __ __	____ YES ____ NO	
7	1600	__ __/__ __/__ __ __ __	__ __ __ __		
7	1800 (before Lofex dose)	__ __/__ __/__ __ __ __	__ __ __ __	____ YES ____ NO	
7	2100	__ __/__ __/__ __ __ __	__ __ __ __		
7	2300 (before Lofex dose)	__ __/__ __/__ __ __ __	__ __ __ __	____ YES ____ NO	
8	0800 (before Lofex dose)	__ __/__ __/__ __ __ __	__ __ __ __	____ YES ____ NO	
10	1000 (after MHOWS)	__ __/__ __/__ __ __ __	__ __ __ __	____ YES ____ NO	

PHYSICIAN=S SIGNATURE: _____ Date:_____

Name Code	Center No.	Screening No.	Patient No.	Study Day	Date Form Completed
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __ / __ __ / __ __ __ __
					Mo Day Year

FORM 30 - SERIOUS ADVERSE EVENT FORM

INVESTIGATOR:	Name:_____ Address:_____ Phone: (__ __ __) __ __ __ - __ __ __ __	
PARTICIPANT DATA:	1. Date Enrolled in Study: __ __ / __ __ / __ __ __ __ 2. Gender: __ (1=Male, 2=Female) 3. Weight: __ __ __ lbs.	4. Date of Birth: __ __ / __ __ / __ __ __ __ 5. Race:_____ 6. Height: __ __ . __ inches

ADVERSE EVENT

7. Type of Event (check all that apply):
   - ___ 1.) Death
   - ___ 2.) Life-threatening
   - ___ 3.) Hospitalization
   - ___ 4.) Disability
   - ___ 5.) Congenital Anomaly
   - ___ 6.) Required intervention to prevent permanent impairment/damage
   - ___ 7.) Other:_____

4 = Remotely

5 = Definitely Not

8. Date of Event Onset: __ __ / __ __ / __ __ __ __

9. Description of Adverse Event
   (symptoms, course, duration, treatment, and sequelae):

_____

_____

_____

_____

_____

_____

_____

_____

10. Severity: _____
    - 1 = Mild
    - 2 = Moderate
    - 3 = Severe

11. Study Drug Related: _____
    - 1 = Definitely
    - 2 = Probably
    - 3 = Possibly

12. Concomitant Drug Related: _____
    1 = Definitely
    2 = Probably
    3 = Possibly
    4 = Remotely
    5 = Definitely Not

13. Action Taken: **Circle all that apply.**
    1 = None
    2 = Remedial Therapy (Pharmacologic)
    3 = Remedial Therapy (Non-Pharmacologic)
    4 = Hospitalization (New or Prolonged)

14. Study Drug Action: _____
    1 = None
    2 = Discontinued Permanently
    3 = Discontinued Temporarily
    4 = Reduced Dose
    5 = Increased Dose
    6 = Delayed Dose

15. Outcome: _____
    1 = Resolved; no sequelae
    2 = Not Resolved
    3 = Resulted in sequelae
    4 = Unknown
    5 = Death* (complete 16, 17, and 18)

16. *Date of Death: __ __ /__ __ /__ __ __ __

17. *Autopsy performed:
    1=Yes ___ 2=No ___

Name Code	Center No.	Screening No.	Patient No.	Date Form Completed
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __/__ __/__ __ __ __
				Mo Day Yr

18. * Probable cause of Death: _____

19. Relevant tests/laboratory data:

_____

_____

_____

_____

_____

_____

20. Describe relevant medical history:

_____

_____

_____

_____

_____

_____

A. Study Drug	B. Route	C. Daily Dose	D. Start Date	E. End Date	F. Lot #

21.			__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	
22.			__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	
23.			__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	
A. Concomitant Med(s)	B. Route	C. Daily Dose	D. Start Date	E. End Date	F. Indication for Use:
24.			__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	
25.			__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	
26.			__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	
27.			__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	
28.			__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	
29.			__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	

Name Code	Center No.	Screening No.	Patient No.	Date Form Completed
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __/__ __/__ __ __ __
				Mo Day Yr

Additional space provided for question 9, Description of Adverse Event:

_____

_____

_____

_____

Physician Signature_____ Date_____

VA/NIDA STUDY 1020

A Phase III Placebo-Controlled, Double-Blind Multi-Site Trial of Lofexidine for Opiate Withdrawal

Name Code	Center No.	Screening No.	Patient No.	Date Form Completed
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __/__ __/__ __ __ __
				Mo Day Year

FORM 31 - END OF STUDY FORM

Month Day Year Study Day

1. Date study participation was discontinued: ☐☐ - ☐☐ - ☐☐☐☐ ☐☐
2. Using the list below, please check the primary reason for ending study participation (check only one):

_____ A. Completed the protocol

_____ B. Subject became ineligible (please circle all that apply below):
1. Pregnancy
2. Failed inclusion or exclusion criteria, specify_____
_____
3. Other reason, specify:_____

_____ C. Toxicity or side effects related to study medication
Specify:

_____ D. Medical reason unrelated to study medication
Specify reason:

_____ E. Discharge for non-compliance

_____ F. Patient's request - Study medication not working (after study day #3)

_____ G. Patient's request - Other reason, specify _____

_____ H. Death (Complete **Serious/Unexpected Adverse Event Form)**

_____ I. Other reason, specify:

FORM COMPLETED BY Date _____

SITE PHYSICIAN'S SIGNATURE Date

VA/NIDA STUDY 1020

A Phase 3 Placebo-Controlled, Double-Blind Multi-Site Trial of Lofexidine for Opiate Withdrawal

Name Code	Center No.	Screening No	Patient No.	Date Form Completed
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __/__ __/__ __ __ __ (Mo / Day / Year)

FORM 32 - FOLLOW-UP

COMPLETE THIS FORM WITHIN 30 DAYS AFTER PATIENT TERMINATES OR COMPLETES THE PROTOCOL

1 = YES
2 = NO

1. Has contact been made with the patient?..... _____
   If YES, **Complete A, B, C, then STOP.**

   A. Date of contact: Mo __ __ Day __ __ Yr __ __ __ __

   B. Does the patient report currently using opiates illicitly?..... _____

   C. Does the patient report currently using other drugs illicitly?..... _____

2. If unable to reach patient, has contact been made with someone who can verify his/her status?..... _____
   If YES:

   A. Date of contact: Mo __ __ Day __ __ Yr __ __ __ __

   B. Person's relationship to patient (check one):
      1. Relative..... _____
      2. Friend..... _____
      3. Other ..... _____

   C. Does the contact report that patient is currently using drugs illicitly? (Code "U" for Unknown)..... _____

3. Has the patient died?..... _____
   If YES:

   A. Date of Death: Mo __ __ Day __ __ Yr __ __ __ __

   B. Cause of Death _____

   C. Information verified by site staff (e.g., coroner's office, death certificate)..... _____

AdditionalComments:_____

_____

_

_____

_ ___

FORM COMPLETED BY_____ Date

_____

VA/NIDA STUDY 1020 - A Phase 3 Placebo-Controlled, Double-blind Multi-site Trial of Lofexidine for Opiate Withdrawal

Name Code	Center No.	Screening No.	Patient No.	Study Day	Assessment Date
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __
					Mo Day Year

FORM 33 - VITAL SIGNS TRACKING

INSTRUCTIONS: The purpose of this form is to track **vital signs, interventions** (used to treat, reduce or eliminate any cardiac event), the **timecourse** of an event and its **resolution**. (Interventions include positional interventions to treat hypotension, IVs, medications other than those approved in the protocol).
Initiate this form when ANY OF THE FOLLOWING OCCUR, and continue use of the form until the episode is resolved.

1) **Abnormal vital signs** occur and are recorded on Form 24. Copy the abnormal vital signs from Form 24 into the first block below, and continue tracking vital signs on this form until resolution of the episode.
2) **Symptoms:** A patient experiences any of the following, with or without abnormal vital signs:
   *Symptoms of hypotension (dizziness, syncope) making it difficult to sit or stand for at least one minute
   *Chest pain (clinically considered to be possible cardiac origin, associated with ECG changes or cardiac enzymes)
   *Clinically significant shortness of breath
   *Decreased level of consciousness
3) Any **medical intervention** (medication or non-medication) is used to treat, reduce or eliminate any cardiac event.

TERMINATION CRITERIA: A patient must be terminated due to the following

1. Clinically significant abnormal ECG (e.g., second or third degree heart block or uncontrolled arrhythmia).
2. Persistent Symptomatic Hypotension. Hypotension not responding to bedrest, which leads to missing more than two doses of study medication in a day.
3. Single Occurrence of Symptomatic Bradycardia. A single occurrence of heart rate less than 60 beats per minute (regardless of blood pressure) associated with chest pain, shortness of breath, or decreased level of consciousness.
4. Persistent Hypertension. Blood pressure greater than 185/110 mmHg recorded on three separate occasions taken at least five minutes apart AND within a one hour time period. All three readings must be greater than or equal to 185/110 - either systolic > 185 mmHg or diastolic > 110 mmHg - to require study termination. (Note: If BP is ≥ 185/110 - this can be either systolic > 185 mmHg or diastolic > 110 mmHg - BP must be taken twice more within the hour, at least 5 minutes apart.)
5. Medical Intervention for Cardiac Event. Any medical intervention (Nonmedication or Medication Inclusive) used for the treatment of any cardiac event, with the exception of a positional intervention in subjects displaying hypotension.
6. Any other clinically significant cardiac sign or symptom that would place the subject at inappropriate risk.

Name Code	Center No.	Screening No.	Patient No.	Study Day	Assessment Date
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __ Mo Day Year

Time hh/mm	Type of Reading 1=Lying 2=Sitting 3=Standing	Temp. (oral) F°	BP Syst/Diast.	Pulse Beats/min	Resp. Breaths/min	Symptoms	Interventions	Resolution
__ __/__ __	____	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			
__ __/__ __	____	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			
__ __/__ __	____	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			
__ __/__ __	____	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			
__ __/__ __	____	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			
__ __/__ __	____	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			

Name Code	**Center No.**	**Screening No.**	**Patient No.**	**Study Day**	**Assessment Date**
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __ **Mo Day Year**

Time hh/mm	**Type of Reading 1=Lying 2=Sitting 3=Standing**	**Temp. (oral) F°**	**BP Syst/Diast.**	**Pulse Beats/min**	**Resp. Breaths/min**	**Symptoms**	**Interventions**	**Resolution**
__ __/__ __	___	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			
__ __/__ __	___	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			
__ __/__ __	___	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			
__ __/__ __	___	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			
__ __/__ __	___	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			
__ __/__ __	___	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			

Name Code	**Center No.**	**Screening No.**	**Patient No.**	**Study Day**	**Assessment Date**
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __
					Mo **Day** **Year**

Time hh/mm	Type of Reading 1=Lying 2=Sitting 3=Standing	Temp. (oral) F°	BP Syst/Diast.	Pulse Beats/min	Resp. Breaths/min	Symptoms	Interventions	Resolution
__ __/__ __	___	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			
__ __/__ __	___	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			
__ __/__ __	___	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			
__ __/__ __	___	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			
__ __/__ __	___	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			
__ __/__ __	___	__ __ . __	__ __ __/__ __ __	__ __ __	__ __ __			

Name Code	Center No.	Screening No.	Patient No.	Study Day	Assessment Date
__ __ __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __/__ __/__ __ __ __
					Mo Day Year

If termination of the patient was necessary, what was the patient's outcome?

_____ **Recovered without additional treatment**

_____ **Additional treatment required, specify**

_____

_____

_____

_____

_____

_____

_____

_____

_____

PHYSICIAN'S SIGNATURE: _____ **Date:** _____

VA/NIDA STUDY 1020

A Phase 3 Placebo-Controlled, Double-Blind Multi-Site Trial of Lofexidine for Opiate Withdrawal

Name Code	Center No.	Screening No.	Patient No.	Study Day	Date of Comment
__ _– __ __	__ __ __	__5__ __ __	__1 __ __ __	__ __	__ __ / __ __ / __ __ __ __
					Mo Day Year

FORM 34 - PRINCIPAL INVESTIGATOR COMMENTS (PICOM)

INSTRUCTIONS: Include the date of entry, whether the comment is related to a protocol Violation, Deviation, Event or Other. Please also confirm that the header information is complete.

A. Date of Occurrence	B . 1=Violation 2=Deviation 3=Event 4=Other	C. Comments
__ __/__ __/__ __ __ __	____	
Signature of person making comment-		
Signature of Site Investigator		

If more comment space is required, obtain an additional PICOM log and appropriately number each of the logs using the space provided.