

Protocol

This trial protocol has been provided by the authors to give readers additional information about their work.

Protocol for: Baeten JM, Palanee-Phillips T, Brown ER, et al. Use of a vaginal ring containing dapivirine for HIV-1 prevention in women. *N Engl J Med* 2016;375:2121-32. DOI: 10.1056/NEJMoa1506110

SUPPLEMENTARY MATERIAL

MTN-020/ASPIRE

This supplement contains the following items:

1. Original protocol and letters of amendment detailing changes to the original protocol
2. Final statistical analysis plan

MTN-020

A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring Containing Dapivirine for the Prevention of HIV-1 Infection in Women

Microbicide Trials Network

Funding Agencies:

**Division of AIDS, US National Institute of Allergy and Infectious Diseases
US National Institute of Mental Health
US National Institutes of Health**

Grant #:

UM1 AI 068633-06

DAIDS Protocol #: 11840

IND Sponsor:

International Partnership for Microbicides

IND# 110,659

Protocol Chair:

Jared Baeten, MD, PhD

Protocol Co-chair:

Thesla Palanee, PhD

Version 1.0

September 28, 2011

MTN-020
A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring Containing Dapivirine for the Prevention of HIV-1 Infection in Women

TABLE OF CONTENTS

LIST OF ABBREVIATIONS AND ACRONYMS.....	v
PROTOCOL TEAM ROSTER.....	viii
INVESTIGATOR SIGNATURE FORM.....	xx
PROTOCOL SUMMARY	xxi
1 KEY ROLES	1
1.1 Protocol Identification.....	1
1.2 Sponsor and Monitor Identification.....	1
1.3 Medical Officer.....	1
1.4 Clinical Laboratories.....	2
1.5 Data Center.....	2
1.6 Study Operations	2
2 INTRODUCTION.....	3
2.1 Microbicides and Human Immunodeficiency Virus (HIV) Prevention	3
2.2 Dapivirine Vaginal Ring.....	6
2.3 Placebo VR.....	8
2.4 <i>In vitro</i> Studies	8
2.5 Condom Compatibility Studies of Dapivirine.....	9
2.6 Clinical Studies	12
2.7 Study Hypothesis and Rationale for Study Design	18
3 OBJECTIVES	20
3.1 Primary Objectives	20
3.2 Secondary Objectives	20
3.3 Exploratory Objectives	20
4 STUDY DESIGN	20
4.1 Identification of Study Design.....	20
4.2 Summary of Major Endpoints	21
4.3 Description of Study Population	21
4.4 Time to Complete Accrual	21
4.5 Study Groups.....	21
4.6 Expected Duration of Participation	21
4.7 Sites.....	22
5 STUDY POPULATION.....	22
5.1 Selection of the Study Population.....	22
5.2 Inclusion Criteria	23
5.3 Exclusion Criteria	24
5.4 Co-enrollment Guidelines.....	26
6 STUDY PRODUCT	27

6.1	Regimen	27
6.2	Administration	27
6.3	Study Product Formulation	27
6.4	Supply and Accountability	28
6.5	Adherence Counseling and Assessment	30
6.6	Concomitant Medications	30
6.7	Use of Intravaginal Medications and Practices	30
7	STUDY PROCEDURES	31
7.1	Pre-Screening	31
7.2	Screening Visit	31
7.3	Enrollment Visit (Day 0)	33
7.4	Follow-up Visits	34
7.5	Follow-up Procedures for Participants Who Temporarily Hold or Permanently Discontinue Study Product	37
7.6	Final Contact	40
7.7	Behavioral Evaluations	40
7.8	Clinical Evaluations and Procedures	41
7.9	Laboratory Evaluations	41
7.10	Primary HIV-1 Endpoint Determination	42
7.11	Specimen Collection and Processing	43
7.12	Specimen Handling	43
7.13	Biohazard Containment	44
8	ASSESSMENT OF SAFETY	44
8.1	Safety Monitoring	44
8.2	Adverse Events Definitions and Reporting Requirements	44
8.3	Expedited Adverse Event Reporting Requirements	47
8.4	Social Harms Reporting	48
8.5	Regulatory Requirements	48
9	CLINICAL MANAGEMENT	49
9.1	Grading System	49
9.2	Dose Modification Instructions	49
9.3	General Criteria for Temporary Hold and Permanent Discontinuation of Study Product	49
9.4	Temporary Product Hold/Permanent Discontinuation in Response to Observed Adverse Events	50
9.5	Genital Sexually Transmitted Infection, Reproductive Tract Infection and Other Clinical Findings	51
9.6	HIV-1 Infection	53
9.7	Pregnancy	53
9.8	Criteria for Early Termination of Study Participation	54
10	STATISTICAL CONSIDERATIONS	54
10.1	Overview and Summary of Design	54
10.2	Study Endpoints	55
10.3	Sample Size and Power Calculations	56
10.4	Participant Accrual, Follow-up and Retention	57
10.5	Randomization	58
10.6	Blinding	58

10.7	Data and Safety Monitoring Procedures.....	58
10.8	Primary Analysis	61
10.9	Analysis of Main Secondary Endpoints	62
10.10	Missing Data	63
11	DATA HANDLING AND RECORDKEEPING	63
11.1	Data Management Responsibilities	63
11.2	Source Documents and Access to Source Data/Documents	64
11.3	Quality Control and Quality Assurance.....	64
12	CLINICAL SITE MONITORING	64
13	HUMAN SUBJECTS PROTECTIONS	65
13.1	Institutional Review Boards/Ethics Committees.....	65
13.2	Protocol Registration.....	65
13.3	Study Coordination.....	66
13.4	Risk Benefit Statement.....	66
13.5	Informed Consent Process.....	68
13.6	Participant Confidentiality.....	69
13.7	Special Populations.....	69
13.8	Compensation.....	70
13.9	Communicable Disease Reporting	70
13.10	Access to HIV-related Care.....	70
13.11	Study Discontinuation	70
14	PUBLICATION POLICY	71
15	APPENDICES.....	72
	APPENDIX I: SCHEDULE OF STUDY VISITS AND EVALUATIONS	73
	APPENDIX II: ALGORITHM FOR HIV ANTIBODY TESTING- SCREENING/ENROLLMENT	75
	APPENDIX III: ALGORITHM FOR HIV ANTIBODY TESTING FOR FOLLOW-UP AND	
	PRIMARY ENDPOINT	76
	APPENDIX IV: SAMPLE INFORMED CONSENT DOCUMENT (SCREENING).....	77
	APPENDIX V: SAMPLE INFORMED CONSENT DOCUMENT (ENROLLMENT)	84
	REFERENCES	94

Table of Figures

Figure 1: Projected Enrollment Used for Study Design.....	57
Table 1: Clinical Phase I/II of Dapivirine Vaginal Rings	14
Table 2: Study Regimen.....	27
Table 3: Retrieval of Study Product.....	29
Table 4: Screening Visit	32
Table 5: Enrollment Visit	33
Table 6: Follow-up Visits: Monthly, Quarterly, Semi-Annually.....	34
Table 7: PUEV	36
Table 8: Study Exit/Termination Visit.....	37

MTN-020

A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring Containing Dapivirine for the Prevention of HIV-1 Infection in Women

LIST OF ABBREVIATIONS AND ACRONYMS

AE	adverse event
ACASI	Audio Computer-Assisted Self Interviewing
AIDS	acquired immunodeficiency syndrome
ALT	alanine aminotransferase
ART	antiretroviral therapy
ARV	antiretroviral
AST	aspartate aminotransferase
ASPIRE	A Study to Prevent Infection with a Ring for Extended Use
AUC	area under plasma concentration-time curve
BRWG	Behavioral Research Working Group
BSWG	Biomedical Science Working Group
CAB	community advisory board
CAPRISA	Centre for the AIDS Programme of Research in South Africa
CBC	complete blood count
CDC	U.S. Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
C _{max}	maximum concentrations
C _{min}	minimum concentrations
CNS	central nervous system
CORE	Coordinating and Operations Center
CRF	Case Report Form
CRPMC	Clinical Research Products Management Center
CT	Chlamydia trachomatis
CTA	clinical trial agreement
CWG	Community Working Group
DAERS	DAIDS Adverse Events Reporting System
DAIDS	Division of Acquired Immunodeficiency Syndrome
DAPY	di-aminopyrimidine
DLV	delavirdine
DNA	deoxyribonucleic acid
DSMB	Data and Safety Monitoring Board
EAE	expedited adverse event
EC	Ethics Committee
EE	ethinyl estradiol
EFV	efavirenz
ENG	etonogestrel
FACTS	Follow on Africa Consortium for Tenofovir Studies
FDA	Food & Drug Administration (U.S.)
FHCRC	Fred Hutchinson Cancer Research Center
g	grams
GC	<i>Neisseria gonorrhoeae</i>
GCP	Good Clinical Practice
GEE	General Estimating Equation
GMP	good manufacturing practices
hCG	human chorionic gonadotropin

HEC	hydroxyethyl cellulose
hu-PBL	human peripheral blood lymphocytes
hu-SCID	human severe combined immunodeficient
HIV-1	human immunodeficiency virus-1
HPTN	HIV Prevention Trials Network
IATA	International Association of Air Transport
IB	Investigator's Brochure
ICF	Informed Consent Form
IFA	immunofluorescent assay
IND	Investigational New Drug
IoR	Investigator of Record
IPM	International Partnership for Microbicides
IRB	Institutional Review Board
ITT	intent-to-treat
IUD	intrauterine device
JHU	Johns Hopkins University
KOH	potassium hydroxide
LDMS	Laboratory Data Management System
LLOQ	lower limit of quantification
µg	microgram
mg	milligram
mL	milliliter
MO	Medical Officer
MOP	Manual of Operational Procedures
MTD	maximum tolerated dose
MTN	Microbicide Trials Network
MU	Makerere University
NAAT	nucleic acid amplification test
NIAID	National Institute of Allergy and Infectious Diseases
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NNRTI	non-nucleoside reverse transcriptase inhibitor
NOAEL	no-observed-adverse-effect-level
NL	Network Laboratory
NRTI	nucleoside reverse transcriptase inhibitor
NVP	nevirapine
OHRP	Office for Human Research Protections
PCR	polymerase chain reaction
PEP	post-exposure prophylaxis
PID	participant identification number
PK	pharmacokinetic
PMPA	Tenofovir 1% gel
PMTCT	Prevention of Mother-to-Child Transmission
PPD	Pharmaceutical Product Development, Inc.
PrEP	pre-exposure prophylaxis
PRO	Protocol Registration Office
PSRT	Protocol Safety Review Team
PTID	participant identification
PUEV	Product Use End Visit
QD	quaque die (once daily)
RNA	ribonucleic acid
RPR	rapid plasma reagin
RSC	Regulatory Support Center
RT	reverse transcriptase
RTI	reproductive tract infection
SAE	serious adverse event

SAP	Statistical Analysis Plan
SCHARP	Statistical Center for HIV/AIDS Research & Prevention
SDMC	Statistical Data Management Center
SHIV	Simian Human Immunodeficiency Virus
SIV	site initiation visit
SMC	Study Monitoring Committee
SSP	study specific procedure(s)
STD	sexually transmitted disease
STI	sexually transmitted infection
TDF	tenofovir disoproxil fumarate
TEAE	treatment emergent adverse event
TPGS	tocopheryl polyethylene glycol succinate
UCSF	University of California- San Francisco
UKZN	University of KwaZulu-Natal
UNAIDS	Joint United Nations Programme on HIV/AIDS
UPMC	University of Pittsburgh Medical Center
USA	United States of America
UTI	urinary tract infection
VOICE	Vaginal and Oral Interventions to Control the Epidemic
VR	vaginal ring
WHO	World Health Organization
wt	wild-type

MTN-020

A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring Containing Dapivirine for the Prevention of HIV-1 Infection in Women

PROTOCOL TEAM ROSTER

Protocol Chair

Jared Baeten, MD, PhD

Protocol Chair

International Clinical Research Center
Department of Global Health, University of Washington
Box 359927
325 Ninth Avenue
Seattle, WA 98104
Phone: 206-520-3808
Fax: 206-520-3831
Email: jbaeten@uw.edu

Protocol Co-chair

Thesla Palanee, PhD

Protocol Co-chair

Wits Reproductive Health and HIV Institute (WRHI)
Research Centre
7 Esselen Street, Hillbrow
Johannesburg, 2038 South Africa
Phone: 27-11-358-5471
Fax: 27-86-554-1093
Email: tpalanee@whri.ac.za

Site Investigators

Site Investigators: South African Medical Research Council Clinical Trials Unit (CTU)

Nicola Coumi, MMed Sci**Site Investigator**

MRC – HPRU

P.O. Box 70380

Overport, KwaZulu-Natal 4067 South Africa

Phone: 27-31-242-3644

Fax: 27-31-242-3800

Email: nicola.coumi@mrc.ac.za**Sarita Naidoo, B Sci****Site Investigator**

MRC – HPRU

P.O. Box 70380

Overport, KwaZulu-Natal 4067 South Africa

Phone: 27-31-242-3667

Fax: 27-31-242-3800

Email: Sarita.Naidoo@mrc.ac.za**Shayhana Ganesh, MBChB, Dip HIV Man****Site Investigator**

MRC – HPRU

P. O. Box 70380

Overport, KwaZulu-Natal 4067 South Africa

Phone: 27-31-242-3600

Fax: 27-31-242-3800

Email: sganesh@mrc.ac.za**Arendevi Pather, B. Pharm.****Site Investigator**

MRC – HPRU

P.O. Box 70380

Overport, KwaZulu-Natal 4067 South Africa

Phone: 27-31-242-3644

Fax: 27-31-242-3800

Email: apather@mrc.ac.za**Sharika Gappoo, MMed Sci****Site Investigator**

MRC – HPRU

P.O. Box 70380

Overport, KwaZulu-Natal 4067 South Africa

Phone: 27-31-242-3645

Fax: 27-31-242-3800

Email: Sharika.Gappoo@mrc.ac.za**Gita Ramjee, PhD****CTU PI**

MRC HIV/AIDS Lead Programme - HPRU

Village Market, 123 Jan Hofmeyer Rd.

Westville, Durban, South Africa

Phone: 27-31-242-3631

Fax: 27-31-242-3800

E-mail: ramjeeg@mrc.ac.za**Vijayanand Guddera, PhD****Site Investigator**

MRC – HPRU

P.O. Box 70380

Overport, KwaZulu-Natal 4067 South Africa

Phone: 27-31-242-3644

Fax: 27-31-242-3800

Email : vguddera@mrc.ac.za**Yukteshwar Sookrajh, MBChB****Site Investigator**

MRC – HPRU

P.O. Box 70380

Overport, KwaZulu-Natal 4067 South Africa

Phone: 27-83-781-1027

Fax: 27-31-902-7938

Email: yuki.sookrajh@mrc.ac.za**Marwah Jenneker, MBChB****Site Investigator**

MRC – HPRU

P.O. Box 70380

Overport, KwaZulu-Natal 4067 South Africa

Phone: 27-39-979-6327

Fax: 27-39-979-4689

Email: mjenneker@mrc.ac.za

Site Investigators: UZ-UCSF Clinical Trials Unit

Zvavahera Mike Chirenje, MD, FRCOG CTU PI

UZ-UCSF Collaborative Research Programme
15 Phillips Avenue
Belgravia
Harare, Zimbabwe
Phone: 263-4-704920
Fax: 263-4-704897
Email: chirenje@uz-ucsf.co.zw

Nyaradzo Mgodzi, MBChB Site Investigator

UC-UCSF Collaborative Research Programme
15 Phillips Avenue, Belgravia
Harare, Zimbabwe
Phone: 263 912 264 616
Fax: 263 4-704897
Email: nmmgodi@uz-ucsf.co.zw

Tsitsi Magure, MBChB, MMed, Obs and Gyn Site Investigator

UZ-UCSF Collaborative Research Programme
15 Phillips Avenue, Belgravia
Harare, Zimbabwe
Phone: 263-1173-3948
Fax: 263-4-704897
Email: tmagure@uz-ucsf.co.zw

Felix Muhlana, MBChB, MMed Site Investigator

UC-UCSF Collaborative Research Programme
15 Phillips Avenue, Belgravia
Harare, Zimbabwe
Phone: 263 912 335 232
Fax: 263 4 704 897
Email: fmhlanga@uz-ucsf.co.zw

Site Investigators: Makerere Univ.- JHU HIV CTU

Clemensia Nakabiito, MBChB, MMed Site Investigator

MU-JHU Research Collaboration
P.O. Box 23491
Kampala, Uganda
Phone: 256-41-541044/256-772-405332
Fax: 256-41-541044/256-41-532091
Email: cnakabiito@mujhu.org

Flavia Matovu Kiweewa, MBChB, Msc. Epidemiology Site-Investigator

MU-JHU Research Collaboration
P.O. Box 23491, Kampala, Uganda
Phone: 256-414-541044/256-772-544759
Fax: 256-414-541044/256-414-532091
Email: fmatovu@mujhu.org

Site Investigator: Wits Reproductive Health and HIV Institute (WRHI)

Modulakgotla Anthony Sebe, MBChB

Site Investigator

WRHI

Research Centre

PO Box 18512, Hillbrow,

Johannesburg 2038

South Africa

Phone: 27-76-599-6736

Fax: 27-86-5681270

Email: asebe@wrhi.ac.za

**Investigators: College of Medicine-John Hopkins University Research Project
Queen Elizabeth Central Hospital**

Bonus Makanani, MBBS, FCOG(SA)

Site Investigator

Chipatala Avenue

P. O. Box 1131

Blantyre, Malawi

Phone: 265-88-8201-702

Fax: 265-1-870-132

Email: bmakanani@jhu.medcol.mw

Newton Kumwenda, MPH, PhD

Site Leader

College of Medicine-Johns Hopkins University Research Project

Queen Elizabeth Central Hospital

PO Box 1131

Chipatala Avenue

Blantyre, Malawi

Phone: 265-1-870-175

Fax: 265-1-870-132

Email: nkumwenda@jhu.medcol.mw

Site Investigator, UNC Lilongwe CRS

Francis Martinson, MB ChB, MPH, PhD

Site Leader

UNC Project

Private Bag A-104

Lilongwe, Malawi

Phone: 265-1-755-954

Fax: 265-1-755-954

Email: fmartinson@unclilongwe.org

Site Investigator, Kamwala Clinic CRS

Margaret Kasaro, MB ChB, MSc PH

Site Investigator

Centre for Infectious Disease Research in Zambia (CIDRZ)

Counting Square Unit C

Thabo Mbeki Road

P. O. Box 34681

Lusaka, Zambia

Phone: 260 955 994834

Fax: 260 211 256559

Email: margaret.kasaro@cidrz.org

US National Institutes of Health (NIH)

Roberta Black, PhD

Microbicide Research Branch Chief

National Institute of Allergy and Infectious Diseases (NIAID), Division of AIDS (DAIDS)

6700 B Rockledge Drive, Room 5135

Bethesda, MD 20817 USA

Phone: 301-496-8199

Fax: 301-402-3684

Email: rblack@niaid.nih.gov

Scharla Estep, RPh, MS

DAIDS Protocol Pharmacist

DAIDS, Pharmaceutical Affairs Branch

6700 B Rockledge Dr., Room 4111

Bethesda, MD 20817 USA

Phone: 301-435-3746

Fax: 301-402-1506

Email: sr72v@nih.gov

Dianne M. Rausch, PhD

Deputy Director

Center for Mental Health Research on AIDS, National Institute of Mental Health (NIMH)

6001 Executive Blvd, Rm 6218, MSC 9619

Bethesda, MD 20892 USA

Phone: 301-443-7281

Fax: 301-443-9719

Email: drausch@mail.nih.gov

Usha Sharma, PhD, MPH

Microbiologist

NIAID/DAIDS

6700 B Rockledge Drive, Room 5117

Bethesda, MD 20892 USA

Phone: 301-451-3441

Fax: 301-496-3684

Email: usharma@niaid.nih.gov

Lydia E. Soto-Torres, MD, MPH

DAIDS Medical Officer

NIAID/DAIDS

6700 B Rockledge Drive

Bethesda, MD 20892-7628 USA

Phone: 301-594-9705

Fax: 301-402-3684

Email: lsoto-torres@niaid.nih.gov

MTN CORE

Katherine Bunge, MD
Protocol Safety Physician
Magee-Womens Hospital of UPMC
300 Halket Street
Pittsburgh, PA 15213 USA
Phone: 412-641-3464
Fax: 412-641-1133
Email: kbunge@mail.magee.edu

Beth Galaska Burzuk, MID
Protocol Development Manager
Microbicide Trials Network
204 Craft Avenue
Pittsburgh, PA 15213 USA
Phone: 412-641-5579
Fax: 412-641-6170
Email: galaskaburzukb@upmc.edu

Betsy Herold, MD
Biomedical Science Working Group
(BSWG) Representative
Albert Einstein College of Med.,
1300 Morris Park Avenue, Forcheimer 702
Bronx, NY 10461 USA
Phone: 718-430-2974
Fax: 718-430-8893
Email: betsy.herold@einstein.yu.edu

Sharon Hillier, PhD
Principal Investigator
Microbicide Trials Network
204 Craft Avenue
Pittsburgh, PA 15213 USA
Phone: 412-641-8933
Fax: 412-641-6170
Email: shillier@mail.magee.edu

Ken Ho, MD
Safety Physician
University of Pittsburgh
Division of Infectious Diseases
Keystone Building, Suite 533
3520 Fifth Avenue
Pittsburgh, PA 15213 USA
Phone: 412-383-7178
Fax: 412-383-2900
Email: hok2@upmc.edu

Cindy Jacobson, PharmD
Director of Pharmacy Affairs
Microbicide Trials Network
204 Craft Avenue
Pittsburgh, PA 15213 USA
Phone: 412-641-8913
Fax: 412-641-6170
Email: cjacobson@mail.magee.edu

Ian McGowan, MD, PhD, FRCP
Co-Principal Investigator
Microbicide Trials Network
204 Craft Avenue
Pittsburgh, PA 15213 USA
Phone: 412-641-8999
Fax: 412-641-6170
Email: imcgowan@pitt.edu

Sharon A. Riddler, MD, MPH
Protocol Physician
UPMC, Keystone Building, Suite 510
3520 Fifth Avenue
Pittsburgh, PA 15213 USA
Phone: 412-383-1741 or 412-383-1675
Fax: 412-383-2900
Email: riddler@dom.pitt.edu

Devika Singh, MD, MPH
Protocol Safety Physician
Box 359927, Dpt. of Global Health
ICRC, 325 Ninth Ave.
Seattle, WA 98104 USA
Phone: 206-744-8311
Fax: 206-520-3831
Email: dsingh@u.washington.edu

MTN Network Laboratory (NL)

Wayne Hall, MT(ASCP) Clinical Laboratory Representative

Microbicide Trials Network
204 Craft Ave. Room A534
Pittsburgh, PA 15213 USA
Phone: 412-641-6956
Fax: 412-641-6170
Email: hallwb@mwri.magee.edu

Craig Hendrix, MD Pharmacology CORE Principal Investigator

Johns Hopkins University
600 North Wolfe Street, Harvey 502
Baltimore, MD 21287 USA
Phone: 410-955-9707
Fax: 410-955-9708
Email: cwhendrix@jhmi.edu

Edward Livant, BSMT (ASCP), MPH MTN NL Research Manager

Microbicide Trials Network
204 Craft Avenue
Pittsburgh, PA 15213 USA
Phone: 412-641-3772
Fax: 412-641-5290
Email: livantew@upmc.edu

John Mellors, MD Virology CORE Principal Investigator

University of Pittsburgh Physicians
3550 Terrace Street
Scaife Hall, Suite 818
Pittsburgh, PA 15261 USA
Phone: 412-624-8512
Fax: 412-383-7982
Email: mellors@dom.pitt.edu

Urvi Parikh, PhD Virology CORE Associate Director

University of Pittsburgh
3550 Terrace Street
Scaife Hall, Suite 817-A
Pittsburgh, PA 15261 USA
Phone: 412-648-3103
Fax: 412-648-8521
Email: ump3@pitt.edu

MTN CORE – FHI 360

Ashley Mayo, MPH
Prevention Research Specialist

FHI 360
P.O. Box 13950
Research Triangle Park, NC 27709 USA
Phone: 919-544-7040 Ext. 11164
Fax: 919-544-7261
Email: amayo@fhi360.org

Kat Richards, MPH
Prevention Research Specialist

FHI 360
P.O. Box 13950
Research Triangle Park, NC 27709 USA
Phone: 919-544-7040 Ext. 11306
Fax: 919-544-7261
Email: krichards@fhi360.org

Katie Schwartz, MPH
Sr. Clinical Research Manager

FHI 360
P.O. Box 13950
Research Triangle Park, NC 27709 USA
Phone: 919-544-7040 Ext. 11425
Fax: 919-544-7261
Email: kschwartz@fhi360.org

Rhonda White, RH Ed
Community Program Manager

FHI 360
PO Box 13950
Research Triangle Park, NC 27709 USA
Phone: 919-544-7040, Ext. 11515
Fax: 919-544-0207
Email: rwhite@fhi360.org

MTN Statistical Data Management Center (SDMC)

Elizabeth Brown, ScD

SDMC Principal Investigator

FHCRC-SCHARP

1100 Fairview Avenue North, M2-C200

PO Box 19024

Seattle, WA 98109-1024 USA

Phone: 206-667-1731

Fax: 206-667-4812

Email: erbrown@fhcrc.org

Missy Cianciola, MS

SDMC Senior Project Manager

FHCRC – SCHARP

1100 Fairview Avenue North, LE-400

PO Box 19024

Seattle, WA 98109-1024 USA

Phone: 206-667-7290

Fax: 206-667-4812

Email: missy@ssharp.org

MTN Behavioral Research Working Group (BRWG)

Juliane Etima, BSc, MA Psy

BRWG Representative

Makerere University - Johns Hopkins University (MU- JHU) Research Collaboration

P.O. Box 23491

Kampala, Uganda

Phone: 256-414-541-044

Fax: 256-772-436-829

Email: jetima@mujhu.org

Barbara S. Mensch, PhD

BRWG Representative

Population Council

1 Dag Hammarskjold Plaza

New York, NY 10017 USA

Phone: 212-339-0640

Fax: 212-755-6052

Email: bmensch@popcouncil.org

Ariane van der Straten, PhD, MPH

BRWG Representative

RTI International

114 Sansome Street, Suite 500

San Francisco, CA 94104 USA

Phone: 415-848-1324

Fax: 415-848-1330

Email: ariane@rti.org

MTN Community Working Group (CWG) Representatives

Mduduzi D Ngubane

CWG Co-representative

Isipingo Clinical Research Site

Medical Research Council

Phone: 27 (031) 902 9474 or +2771 423 4106

Fax: 27 (031) 902 7938

Email: Mduduzi.ngubane@mrc.ac.za

Oupa Mafumane

CWG Co-representative

552 Mngqibisa Street, Klipspruit

P.O. Pimville 1809

Soweto, Johannesburg, South Africa 2001

Phone: 27-11-358-5424

Fax: 27-11-358-5381

Email: opzyno@hotmail.com

MTN-020

A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring Containing Dapivirine for the Prevention of HIV-1 Infection in Women

INVESTIGATOR SIGNATURE FORM

Version 1.0

September 28, 2011

A Study of the Microbicide Trials Network

Funded by:

Division of AIDS, US National Institute of Allergy and Infectious Diseases
US National Institute of Mental Health
US National Institutes of Health

IND Holder:

International Partnership for Microbicides

I, the Investigator of Record, agree to conduct this study in full accordance with the provisions of this protocol. I will comply with all requirements regarding the obligations of investigators as outlined in the Statement of Investigator (Form FDA 1572), which I have also signed. I agree to maintain all study documentation for at least two years following the date of marketing approval for Vaginal Matrix Ring Containing Dapivirine for the indication in which it was studied. If no marketing application is filed, or if the application is not approved, the records will be retained for two years after the investigation is discontinued and the US Food and Drug Administration is notified. Publication of the results of this study will be governed by the Microbicide Trials Network (MTN) and International Partnership for Microbicides (IPM) policies. Any presentation, abstract, or manuscript will be submitted to the MTN Manuscript Review Committee, DAIDS, NIAIDS, NIH, NIMH, and IPM for review prior to submission.

I have read and understand the information in the Investigator's Brochure(s), including the potential risks and side effects of the products under investigation, and will ensure that all associates, colleagues, and employees assisting in the conduct of the study are informed about the obligations incurred by their contribution to the study.

Name of Investigator of Record

Signature of Investigator of Record

Date

MTN-020

A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring Containing Dapivirine for the Prevention of HIV-1 Infection in Women

PROTOCOL SUMMARY

Short Title: A Study to Prevent Infection with a Ring for Extended Use (ASPIRE)

Clinical Phase: Phase 3

IND Sponsor: International Partnership for Microbicides

Protocol Chair: Jared Baeten, MD, PhD

Protocol Co-chair: Thesla Palanee, PhD

Sample Size: Approximately 3476 women

Study Population: Sexually active HIV-uninfected women, non-pregnant, 18-45 years of age

Study Sites: Sites selected by the MTN Executive Committee

Study Design: Multi-center, two-arm, randomized (1:1), double-blind, placebo-controlled Phase 3 trial

Study Duration: Accrual will require approximately 12 months. Each participant will engage in the screening process for up to 4 weeks (28 days) prior to enrollment and will use investigational product until 120 events (HIV-1 seroconversions) are observed in the trial. Based on the statistical assumptions listed below, the targeted number of incident seroconversions is expected to be reached approximately 12 months after the date upon which the last participant enrolls in the trial.

Each participant will have 4 additional weeks of follow-up after ring discontinuation, to identify HIV-1 seroconversions that are not detected during the product-use period.

Study Products:

- Dapivirine Vaginal Ring (VR)
- Placebo VR

Study Regimen: Participants will be randomized in a 1:1 ratio to receive either a silicone elastomer vaginal matrix ring containing 25 mg of dapivirine or a placebo VR

Primary Objectives:

- To determine the *effectiveness* of dapivirine (25 mg) administered in a silicone elastomer vaginal matrix ring, when inserted once every 4 weeks, in preventing HIV-1 infection among healthy sexually active HIV-uninfected women
- To assess the *safety* of dapivirine (25 mg) administered in a silicone elastomer vaginal matrix ring, when inserted once every 4 weeks over the investigational product use period

Primary Endpoints:

- **Effectiveness**
 - HIV-1 infection as measured by seroconversion at the end of the investigational product use period with seroconversion defined by the algorithm in Appendix III
- **Safety**
 - Grade 2 adverse events (AEs) judged to be related to study product
 - Grade 3 and 4 AEs
 - All serious adverse events

Secondary Objectives:

- To evaluate the *acceptability* of the study VR (dapivirine or placebo) in HIV-uninfected women, when inserted once every 4 weeks over the investigational product use period
- To evaluate the *adherence* to the study VR (dapivirine or placebo) in HIV-uninfected women, when inserted once every 4 weeks over the investigational product use period
- To assess the frequency of HIV-1 *drug resistance* in women who acquire HIV-1 infection while using the investigational product
- To evaluate the *relationship between drug concentration and HIV-1 seroconversion*

Secondary Endpoints:

- **Acceptability**
 - Participant report of participant and partner-related acceptability including (dis)comfort, ring insertion and removal/ expulsion issues, change in sexual feelings, willingness to use in the future
- **Adherence**
 - Frequency of study VR removal/expulsions (voluntary and involuntary) and duration without VR inserted in vagina
- **HIV-1 Drug Resistance**
 - HIV-1 drug resistance mutations among participants who acquire HIV-1 infection
- **Drug Concentration Data**
 - Steady-state drug concentrations in blood and vaginal fluid

Exploratory Objectives:

- Describe changes in the *genital microenvironment*
- To assess *correlation of steady-state drug concentration and adherence measures*
- To assess the *incidence of HIV-1 seroconversion* during 4 weeks off study product, between the product use end visit (PUEV) and termination visit

Exploratory Endpoints:

- **Genital microenvironment changes**
 - Changes in candidate biomarkers of safety and efficacy
- **Correlation of steady-state drug concentration and adherence measures**
 - Adherence measures as outlined above for the secondary objective
 - Steady-state drug concentration
- **Delayed seroconversion**
 - HIV-1 infection as measured by seroconversion (according to the algorithm in Appendix III) during the approximate 4 weeks of follow-up off study product between the PUEV and termination visit.

1 KEY ROLES

1.1 Protocol Identification

Protocol Title: A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring with Dapivirine for the Prevention of HIV-1 Infection in Women

Protocol Number: MTN-020

Short Title: A Study to Prevent Infection with a Ring for Extended Use (ASPIRE)

Date: September 28, 2011

1.2 Sponsor and Monitor Identification

Funding Agencies: US Division of AIDS (DAIDS)/National Institute of Allergy and Infectious Diseases (NIAID)
National Institutes of Health (NIH)
6700 B Rockledge Drive
Bethesda, MD 20892 USA

US National Institute of Mental Health (NIMH)
6001 Executive Boulevard
Rockville, MD 20852 USA

IND Sponsor: International Partnership for Microbicides (IPM)
8401 Colesville Rd., Suite 200
Silver Spring, MD 20910 USA

Monitor: PPD, Inc.
929 North Front Street
Wilmington, NC 28401 USA

1.3 Medical Officer

Medical Officer: Lydia E. Soto-Torres, MD, MPH
6700 B Rockledge Drive
Bethesda, MD 20892-7628 USA

1.4 Clinical Laboratories

Network Laboratory: MTN Network Laboratory (NL)
204 Craft Avenue
Pittsburgh, PA 15213 USA

Pharmacology: MTN NL Pharmacology CORE
600 N. Wolfe Street, Osler 527
Johns Hopkins University
Baltimore, MD 21287 USA

1.5 Data Center

Data Center: Statistical Center for HIV/AIDS Research & Prevention
(SCHARP)/Fred Hutchinson Cancer Research Center
(FHCRC)
1100 Fairview Avenue N., LE-400
PO Box 19024
Seattle, WA 98109-1024 USA

1.6 Study Operations

Study Operations: FHI 360
PO Box 13950
Research Triangle Park, NC 27709 USA

2 INTRODUCTION

2.1 Microbicides and Human Immunodeficiency Virus (HIV) Prevention

In 2009, 1.8 million people became newly infected with HIV and 2 million lost their lives to acquired immunodeficiency syndrome (AIDS). According to the Joint United Nations Programme on Human Immunodeficiency Virus-1(HIV)/AIDS (UNAIDS) Global Report, an estimated total number of individuals living with HIV is 33.3 million, of those, 22.5 million reside in sub-Saharan Africa.¹ The on-going development of safe and effective HIV prevention technologies that can be made easily accessible to developing countries remains a public health priority.

Epidemiologic data published in the UNAIDS/World Health Organization (WHO) “AIDS Epidemic Report 2009” show that women and girls continue to be affected disproportionately by HIV in sub-Saharan Africa, where women account for approximately 60% of people living with HIV.¹ Unprotected heterosexual intercourse is currently the leading mode of HIV transmission among women. Correct and consistent use of latex condoms is one proven method of preventing HIV transmission; however, condoms are widely regarded as inadequate prevention options for women, because many women are unable to negotiate condom use with their partners. Most current HIV prevention methods require the consent of the male partner.²

Developing HIV prevention options that women can use remains a global concern, given the high rates of HIV infection among women. Vaginal microbicides, which are self-initiated, offer women a critically needed new tool to prevent HIV, complementing existing HIV prevention strategies or future ones that are being developed. An “early generation” of microbicide candidates were tested in Phase 2 trials. The candidates were primarily made of large molecules without direct activity against HIV; none of these products proved effective in preventing HIV transmission. In addition, the ALVAC-AIDSVAX HIV vaccine trial showed only modest effectiveness and research continues to find new vaccine candidates to advance into Phase 3 trials.³

Following unsuccessful efforts to develop these non-specific microbicides, the new microbicide candidates, based on highly-specific antiretroviral (ARV) drugs, are currently undergoing extensive safety and effectiveness trials. Unlike early-generation products, which were primarily evaluated in gel formulation delivered via a single-use vaginal applicator used prior to sexual intercourse, ARV-based compounds specifically target HIV infection and can be designed in formulations for more flexible use, including daily or monthly use, independent of sexual activity.

Some recently completed and on-going studies are exploring whether oral daily ARVs taken as pre-exposure prophylaxis (PrEP) are safe and effective for HIV prevention. Recently completed studies are presented below.

CAPRISA 004

In July 2010, in an important milestone for HIV prevention, the Centre for the AIDS Programme of Research in South Africa (CAPRISA) 004 Phase 2B microbicide trial found a 39% lower HIV infection rate in women using 1% tenofovir gel as compared to the women using a placebo gel when used in a coitally dependant regimen. The drug was found to be 54% effective amongst women who were the highest adherers (gel adherence > 80%). Tenofovir gel is the first ARV-based microbicide to be tested in an effectiveness trial. In addition, tenofovir gel was shown to be safe when used up to 12 hours before sex and again within 12 hours after sex, for a maximum of two doses in 24 hours. Participants who adhered to the dosing regimen in more than 80% of sex acts were the least likely to acquire HIV (54% lower risk of infection).⁴

CDC 4323

CDC 4323 was a Phase 2 extended safety study of tenofovir-disoproxil fumarate (TDF) among HIV-negative men carried out at three US sites. This trial was designed to examine the safety of TDF for HIV prevention in HIV-negative men who have sex with men. Preliminary data announced in July 2010 showed no serious safety concerns on the basis of the preliminary analysis.⁵

iPrEx Study

The iPrEx study, a randomized, double-blind, Phase 3 clinical trial conducted in the United States, Brazil, Ecuador, Peru, South Africa and Thailand was designed to determine whether FTC/TDF (200 mg/300 mg) tablets could safely and effectively prevent HIV infection among men who have sex with men (MSM) and transgendered women who have sex with men, when taken daily.⁶ Participants were randomized to receive either oral FTC/TDF or placebo. All participants were routinely counseled about safe sex practices, provided condoms and treated for sexually transmitted infections. Study participants were followed for 3324 person-years (median, 1.2 years; maximum, 2.8 years). Participants who took the daily dose of oral FTC/TDF experienced an average of 44% fewer HIV infections than those who received a placebo pill (95% CI, 15 to 63; $P=0.005$). A total of 100 participants seroconverted while enrolled in the iPrEx study. Of those, 36 HIV infections occurred among the 1,251 participants randomized to receive FTC/TDF compared with 64 HIV infections among the 1,248 participants who were randomized to receive placebo. Oral FTC/TDF was found to be most effective among participants who were adherent to the daily drug regimen. Participants who took the drug on 50% or more days as measured by pill count, self-report, and dispensation records, experienced 50.2% fewer HIV infections (95% CI, 18 to 70; $P=0.006$). Those who took the drug on 90% or more days presented 73% fewer HIV infections (95% CI, 41 to 88; $P=0.001$). Overall, efficacy was greatest among participants who, at the time of enrollment, were at highest risk for HIV acquisition (58%), as captured by self-reports of unprotected receptive anal intercourse. Drug resistance mutations to FTC occurred in 3 participants, 2 of these from the FTC/TDF arm and one from the placebo arm, and all 3 of whom were infected at the time of enrollment. No resistance was observed in any participant with incident HIV infection.

FEM-PrEP Study

The FEM-PrEP Study is a Phase 3, randomized, placebo-controlled, trial of the effectiveness of daily oral FTC/TDF for HIV prevention among HIV-uninfected women in Kenya, South Africa and Tanzania. The FEM-PrEP study enrolled HIV-negative women between the ages of 18 and 35 who were at higher risk for HIV. Higher risk was defined as: 1) has had at least one vaginal sex act in the last two weeks, or 2) has had more than one sexual partner in the last month. Only women who used study-approved contraception at enrollment were eligible for participation. The study was conducted at four sites in three countries (Bondo, Kenya; Bloemfontein and Pretoria, South Africa; and Arusha, Tanzania). All participants in the study were provided comprehensive HIV prevention services, including male and female condoms, intensive risk-reduction behavioral counseling, and testing and treatment for sexually transmitted infections. This trial was designed to close at 72 HIV endpoints; however, during a scheduled review by the trial's Independent Data Monitoring Committee (IDMC) on April 7, 2011, the trial had accumulated 56 endpoints, with 28 endpoints in the FTC/TDF arm and 28 endpoints in the placebo arm, leaving 16 endpoints until the trial was complete.⁷ The trial was stopped early due to futility. No significant safety concerns were noted. Pregnancy rates were noted to be higher in women taking hormonal contraceptives (at the onset of participation) and FTC/TDF compared with those taking hormonal contraceptives and the placebo. Final study results are expected to be available in late 2011 or early 2012.

TDF2

The TDF2 Study is a Phase 2B study that assessed the safety, adherence and efficacy of daily oral FTC/TDF in 1,200 HIV-uninfected heterosexual male and female participants aged 18-39.⁸ The trial, originally known as the Botswana PrEP Study, began in 2005 as a Phase 3 trial of TDF. In 2007, the study product was changed to FTC/TDF. In 2009, the completed enrollment of 1,200 participants, but due to lower than expected HIV incidence and suboptimal retention, it was determined that the study would not be able to answer its primary objective of efficacy. The trial continued, but with intent to evaluate safety and adherence. Of the 1,200 participants in the TDF2 Study, 45% of whom were women, 601 were randomly assigned to FTC/TDF, and 599 were assigned to placebo. All participants were provided comprehensive HIV prevention services, including male and female condoms, intensive risk-reduction behavioral counseling, and testing and treatment for sexually transmitted infections. During the study, 33 of 1,200 participants acquired HIV (nine of the 601 participants on the FTC/TDF arm and 24 participants of the 599 on the placebo arm), corresponding to a 62.6% reduction in HIV acquisition for those assigned to FTC/TDF, compared to placebo (HR 0.37, CI 21.5-83.4, P = 0.013). Among 21 total HIV endpoints in women in the trial, 7 were in the FTC/TDF arm and 14 were in the placebo arm. While results for the subset of women in the trial did not meet statistical significance (HR 0.51, CI -0.217-80.8, P = 0.107), a non-intent-to-treat (ITT) analysis among women thought to have a supply of study drug (3 HIV endpoints in the FTC/TDF arm and 13 in the placebo arm) found an estimated efficacy of 75.5%, P = 0.021. No significant safety concerns were noted, though participants randomized to the FTC/TDF arm did experience more nausea, vomiting, and dizziness than those randomized to placebo.

In addition, tenofovir gel is also being tested in a non-coitally dependant regimen of once-daily product in the MTN-003 (VOICE). VOICE is a Phase 2B trial currently ongoing in Uganda, Zimbabwe, and South Africa. An additional confirmatory Phase 3 trial, Follow on Africa Consortium for Tenofovir Studies (FACTS) 001, with tenofovir gel plans to use the same coitally dependant regimen of CAPRISA 004 and is planned to start in 2011.

With successful proof-of-concept that an ARV-based microbicide can reduce the risk of HIV-1 acquisition, ARV prevention approaches have the potential to transform the response to the HIV/AIDS epidemic. In addition to confirmatory work on tenofovir gel, further trials are needed on microbicides that contain different ARV compounds in different formulations using different dosing strategies, to provide options and improve upon the level of effectiveness seen in CAPRISA 004.

For a microbicide to be most effective, it is essential that it is used correctly and consistently, and is acceptable to the user. In addition, a product used independently of sex could be more convenient for women and provide long-term protection during anticipated and unanticipated sexual intercourse. As seen in the CAPRISA 004 trial higher adherence to product may translate into higher effectiveness of the product. It is likely that products that can be applied less frequently will be more acceptable and will achieve better adherence. Vaginal rings that need to be replaced every 4 weeks may have benefits over dosage forms that need to be used more frequently. The dapivirine (25 mg) silicone elastomer vaginal ring (VR) is the lead VR candidate for advancement to Phase 3 clinical testing.

Multiple clinical trials⁹⁻¹⁵ have evaluated the safety of dapivirine in VRs, gels and in an oral formulation. These clinical trials support the favorable safety profile and tolerability of dapivirine in general and specifically in vaginal delivery formulations.

2.2 Dapivirine Vaginal Ring

2.2.1 Description

Dapivirine, a non-nucleoside reverse-transcriptase inhibitors (NNRTI), is a substituted di-amino-pyrimidine (DAPY) derivative with potent antiviral activity against HIV-1. Dapivirine is chemically described as 4-[[4-[(2,4,6-trimethylphenyl)amino]-2-pyrimidinyl]amino]benzotrile.¹⁴ The dapivirine matrix VR is a flexible ring containing 25 mg of drug substance dispersed in a platinum-catalyzed-cured silicone matrix. Dapivirine is known to be well-suited for delivery via VR, as evidenced by favorable safety and pharmacokinetic data to date described below.

Dapivirine was originally developed by Tibotec Pharmaceuticals (Titusville, NJ) as an oral ARV compound and was tested in Phase 1 and 2 clinical trials in more than 200 participants.¹² Although first conceived as an oral therapeutic, dapivirine became a promising topical microbicide candidate due to its proven *in vitro* and *in vivo* efficacy

and favorable safety profile as well as its physical and chemical properties. Dapivirine has potent activity against wild-type HIV-1 strains and strains harboring different resistance-inducing mutations. Dapivirine's ARV profile is superior to that of other NNRTI drugs, including nevirapine (NVP), delavirdine (DLV), and efavirenz (EFV). Comparable to other NNRTIs, *in vitro* tests have also shown that dapivirine has limited efficacy against HIV-2 and no efficacy against common sexually transmitted infections (STI). Dapivirine is therefore not intended to have activity against HIV-2 or other STIs, nor does it have any contraceptive properties.¹⁶ Detailed information on dapivirine is available in the Dapivirine VR Investigator's Brochure (IB).¹⁷

IPM has investigated a wide range of dosage forms for the development of topical microbicide products, including vaginal gels, rings, films, tablets and soft gel capsules. The vaginal gel was the initial dosage form chosen for a dapivirine-based microbicide because the majority of previous microbicides to have entered clinical trials were also in vaginal gel forms and therefore a wealth of information was available on that dosage form. However, the dapivirine silicone elastomer VR has now been prioritized over all other dosage forms for the following reasons:

- Clinical trials have demonstrated sustained delivery of high levels of dapivirine throughout the cervicovaginal vault for up to 1 month;
- Since the ring is able to deliver drug for at least 1 month, the burden of user-dependent adherence is lower than for once daily products;
- Product acceptability studies and the experience gained from marketed VR products have established a high level of acceptance and adherence from women using VR with similar physical characteristics;
- The overall cost for the ring is relatively low;
- Minimal storage space is required for the ring when compared with once daily products.

The safety and tolerability of dapivirine has been evaluated by IPM and Tibotec Pharmaceuticals in both animal and human studies via the oral and vaginal routes. Below is a summary of the data collected through these studies.

2.2.2 Mechanism of Action

Dapivirine is an NNRTI; NNRTIs bind to the HIV reverse transcriptase (RT) enzyme preventing viral replication and therefore the production of infectious virus.

2.2.3 Strength of Study Product

The dapivirine VR will contain 25 mg of dapivirine. This is the same drug load as was used in dapivirine rings previously tested and/or planned for in five trials involving 77 participants, including two 28-day trials (IPM) involving HIV-uninfected women using Ring-004. The current formulation is a dapivirine matrix VR containing 25 mg of drug substance dispersed in a platinum-catalyzed-cured silicone matrix. In addition, platinum-catalyzed matrix VRs containing 25 mg of dapivirine were studied in IPM 013

over an approximately 8-week period with a 4-week follow-up among healthy, sexually active HIV-uninfected women. Finally, IPM 015 a Phase 1/2 double-blind placebo-controlled trial randomized 140 women to dapivirine VR use. Participants from Kenya, Malawi, South Africa, and Tanzania inserted a dapivirine VR once every 28 days over a 12-week period. Data analysis of this trial is ongoing.

2.3 Placebo VR

2.3.1 Description

The placebo VR is a flexible, platinum-catalyzed-cured silicone matrix ring which contains no active drug.

2.3.2 Mechanism of Action

The placebo VR is designed to be inactive in the vagina.

2.3.3 Strength of Study Product

The placebo VR contains no active drug.

2.4 *In vitro* Studies

2.4.1 *In vitro* Studies of Dapivirine

Anti-HIV-1 Activity

The activity of dapivirine against wild-type (wt) HIV-1, African isolates of HIV-1 (including subtype C virus), and a panel of NNRTI-resistant viruses has been established using *in vitro* models, with 50% effective concentration (EC₅₀) values ranging from 0.3 ng/mL (0.9 nM) against laboratory isolates to <33 ng/mL (<100 nM) for HIV-1 isolates encoding one or more known NNRTI resistance mutations.^{14,18}

Resistance

HIV-1 virus breakthrough in the presence of dapivirine was initially evaluated in studies in which cells were infected with wild-type HIV-1 laboratory strains at high multiplicity of infection and in the presence of high concentrations of dapivirine. At 40 nM virus breakthrough occurred between 4 and 7 days, at 200 nM between 7 and 10 days and at 1 μM it took up to 30 days to observe virus growth. In all cases mutations were present. Virus selected with the Y181C mutation was resistant to dapivirine. Subsequently, cells were infected with wild-type HIV-1 at low multiplicity of infection and were exposed to very low concentrations of dapivirine to mimic the extremely low systemic concentrations observed in the first clinical trial of one formulation of topical dapivirine (Gel-001).

In the first experiment, population sequencing performed following prolonged exposure of HIV-1_{LAI}-infected MT4 cells to low concentrations of dapivirine for a period of approximately 30 days identified several NNRTI resistance-associated mutations, including Y181C, at dapivirine concentrations of 10 nM and 100 nM, but not at 1 nM and 0.1 nM concentrations. However, both Y181C and V179I were detected when single viral genomes were analyzed by end-point dilution at 1 and 0.1 nM concentrations. The frequency of Y181C was 10-12% both at 1 and 0.1 nM.

In a second series of experiments using the same and lower dapivirine concentrations, population sequencing identified the Y181C mutation at 1 nM, but not at lower concentrations. Analysis using a more sensitive end-point dilution technique in which the genotypic sequence of 25 to 30 individual viral genomes was determined indicated the presence of Y181C at 0.1 nM, and possibly 0.01 nM (approximately 10-fold lower than the EC₅₀ for dapivirine).

The significance of Y181C in a single clone at 0.01 nM in the 31-day culture is not clear. It is possible that the sensitive single genome sequencing technology detected some of the pre-existing natural variants present in a virus population in the absence of selective pressure. It was concluded that prolonged exposure to low concentrations of dapivirine can result in selection of viruses carrying NNRTI resistance-associated mutations, but the clinical relevance of these *in vitro* data is not known.¹⁴

Cross-resistance

In comparison with NVP, DLV, EFV and emivirine, dapivirine showed significantly better *in vitro* activity against laboratory and recombinant HIV strains resistant to one or more drugs of the same class. The EC₅₀ was below 32.9 ng/mL (100 nM) for 80% of the strains compared with only 56% of the strains for EFV.

When tested against 433 clinical isolates with phenotypic resistance to at least one of the NNRTIs NVP, DLV, EFV or dapivirine, dapivirine was able to inhibit 46% (202/433) of the samples including 41% (142/350) of the strains resistant to EFV. In contrast, only 10% (24/231) of the dapivirine-resistant strains were inhibited by EFV.¹⁴

2.5 Condom Compatibility Studies of Dapivirine

Condom compatibility studies have not been conducted with the VR; however, chemical compatibility studies with different dapivirine containing gel formulations were conducted on the following types of condoms:¹⁹

- Non-lubricated latex condoms (male condom);
- Silicone lubricated latex condoms (male and female condoms);
- Aqueous lubricated latex condoms (male condom);
- Polyurethane condoms with silicone lubricant (male and female condoms); and
- Nitrile condoms with silicone lubricant (female condom).

The results of condom compatibility testing indicate that dapivirine-containing vaginal gel formulations (0.05%) have no deleterious effects on the integrity of male or female condoms, as indicated by airburst and tensile condom properties tested pre- and post-treatment.

All types of condoms met the acceptance criteria established in the protocol for the mean values of the treated samples after treatment with gels. Additionally, all airburst data for treated samples met the ISO 4074:2002 and ASTM D3492 release criteria requirements.

2.5.1 Nonclinical Studies of Dapivirine

Pharmacokinetics

Systemic exposure to dapivirine was low following vaginal administration of dapivirine gels to rabbits.¹⁴ Much higher systemic exposures were obtained in single-dose oral and subcutaneous toxicity studies in mice and rats, and in repeat dose oral toxicity studies in rats, dogs and monkeys. The free fraction of dapivirine in plasma was 0.19-0.34% in the male rat, 0.18-0.39% in the female rat, 0.21-0.22% in the dog and 0.15% in humans. In rats, tissue-to-plasma area under plasma concentration-time curve (AUC)₀₋₂₄ ratios following a single oral dose were 11 in liver, 7-8 in lung, kidney and adrenals, about 4 in spleen and lymph nodes, and 2-3 in brain, heart and muscle. Plasma/tissue equilibrium was rapid, and there was no undue retention of dapivirine in tissues. Following a single oral or vaginal dose of ¹⁴C-dapivirine, absorption and distribution of drug-related material to the tissues was moderate in non-pregnant and slow in pregnant female rats. Vaginal dosing did not result in greater distribution to the reproductive tissues (except the vaginal wall) than oral dosing. For virtually all tissues, maximal concentrations after vaginal dosing were <1% of those after oral dosing. Drug-related material was shown to freely cross the placenta to the fetus. In dogs, dapivirine concentrations following oral administration for 14 days were about 9 times higher in liver and muscle, and about 5 times higher in lymph nodes and brain than in plasma. Preliminary metabolism studies demonstrated the presence of free and conjugated metabolites in rats, dogs, monkeys and humans, but the molecular structures have not been elucidated. There was evidence of extensive cytochrome P450 (particularly CYP3A4) mediated metabolism.¹⁴

Toxicology

The toxicity of dapivirine has been evaluated in a comprehensive program of preclinical studies. These are described in the IB and included repeat dose vaginal toxicity studies in rabbits using gel formulations of dapivirine at concentrations up to 20 mg/mL for 14 days, up to 5 mg/mL for 13 weeks or up to 2 mg/mL for 39 weeks (dose volume = 1 mL/day).¹⁷ No local or systemic toxicity was identified in any of these studies. In addition, studies of up to 26 weeks duration were completed in rats and dogs via the oral route. The no-observed-adverse-effect-level (NOAEL) in both species following oral administration was 20 mg/kg/day. C_{max} at the NOAEL was 0.39 µg/mL in rats and 1.21 µg/mL in dogs, which was more than 1000 and 3400 times, respectively, the maximum mean plasma concentration (0.355 ng/mL) in women using a dapivirine ring

(Ring-004) for 28 days. AUC at the NOAEL was 4.80 µg.h/mL in rats and 12.98 µg.h/mL in dogs, which is over 1500 and 4200 times, respectively, the mean AUC (3.022 ng.h/mL) in women using Ring-004 for 28 days.

Mutagenesis

Dapivirine was considered to be non-genotoxic based on the results from a range of *in vitro* and *in vivo* mutagenicity assays, including the Ames Test, L5178Y Mouse Lymphoma Test, Mouse Micronucleus Test, and Unscheduled Deoxyribonucleic Acid (DNA) Synthesis Test.

Reproductive Toxicity

In rats, some effects on the developing fetus were observed following oral administration at maternally toxic doses (80 and 320 mg/kg) of dapivirine. However, there were no effects in rats at the maternally non-toxic dose of 20 mg/kg/day, or in rabbits at up to 90 mg/kg. No toxicity to maternal animals or the developing embryo/fetus was seen following vaginal dosing in embryo-fetal development studies in rats (up to 3.3 mg/mL using a dose volume of 0.2 mL/kg) and rabbits (up to 2 mg/mL using a dose volume of 1.0 mL).¹⁷

Vaginal reproductive toxicity trials in rats and rabbits using a formulation of dapivirine gel (Gel-001) at nominal concentrations up to 3.3 mg/mL (10 mM) or another formulation of dapivirine gel (Gel-002) at up to 2.0 mg/mL (0.2%) did not identify any adverse effects on the maternal animals or the developing embryo/fetus.¹⁷

Effectiveness

Dapivirine blocked vaginal transmission of HIV-1 in a hu-SCID mouse model in which animals received a single vaginal application of dapivirine gel (candidate research gels containing either Carbopol 940 or hydroxyethylcellulose (HEC)) prior to a non-invasive vaginal challenge with human peripheral blood lymphocytes (hu-PBL) previously infected *in vitro* with CCR5-tropic and dual tropic (CCR5/CXCR4) HIV-1 strains. Dapivirine prevented a systemic infection with either CCR5 or CCR5/CXCR4 virus strains at concentrations of 2.25 µM (0.7 µg/mL) and higher. The efficacy rate ranged from approximately 70 to 100%, depending on the vaginal gel formulation. The protection resulted directly from the ARV activity of dapivirine, since placebo gels failed to protect and since dapivirine did not show toxicity using mock-infected hu-PBL. Results were better with gels of lower viscosity, probably reflecting the ease with which the vaginal gel was applied to the vagina and thus either the uniformity of distribution over the entire vagina/cervix or the non-traumatic application of the vaginal gel.¹⁸

Anti-HIV Activity

The anti-HIV activity was also confirmed in an *ex vivo* model of human cervical explant cultures and a humanized severe combined immunodeficient (hu-SCID) mouse model.^{14,18} Pre-treatment of tissue with dapivirine for 2 or 24 hours inhibited HIV-1 infection when challenged with virus on Days 0, 2, 4 and 6 post drug removal. Dapivirine was also able to inhibit virus dissemination by migratory cells up to 6 days post drug removal at concentrations down to 10 µM (3.3 µg/mL) following treatment for

2 or 24 hours. In addition, dapivirine (32.9 ng/mL) was able to block transfer of free virus by migratory dendritic cells to indicator T-cells (IC₅₀= 0.1 nM [0.03 ng/mL]).¹⁷

2.6 Clinical Studies

2.6.1 Clinical Studies of Dapivirine

To date, 25 Phase 1 and Phase 1/2 clinical trials of dapivirine have been conducted or are currently underway: six trials of dapivirine VRs in which 222 participants were assigned to dapivirine VRs, eight trials of dapivirine vaginal gel in which 491 participants used dapivirine vaginal gel, and 11 trials of oral dapivirine among 211 participants.¹⁴

Pharmacokinetics

Dapivirine vaginal rings

Previously, IPM conducted a 28-day trial (IPM 018) in HIV-uninfected women using tin catalyzed silicone matrix and reservoir rings containing 25 mg of dapivirine. The goal of that trial was to determine the safety and PK of dapivirine delivered from these rings. The rings were found to be generally safe and well-tolerated with a promising drug release profile.²⁰

IPM also conducted a 28-day trial (IPM 024) involving 16 healthy, HIV-uninfected, sexually abstinent women, between 18 and 40 years of age. The women were randomly assigned (1:1) to a dapivirine (25 mg) matrix ring or a placebo ring for 28 consecutive days. Post-ring insertion (1.5 hour), quantifiable plasma dapivirine concentrations (lower limit of quantification (LLOQ) = 3.00 pg/mL) were observed. These concentrations showed a gradual increase over time, reaching a mean C_{max} of 355.0 pg/mL by Day 7 (median T_{max}).

The individual plasma dapivirine concentrations did not exceed 1 ng/mL, well below plasma levels at the maximum tolerated dose (MTD) for oral treatment.

For dapivirine in vaginal fluids quantifiable concentrations (LLOQ = 0.40 ng) were also observed 1.5 hours after ring insertion. Generally, maximum concentrations were reached earlier than in plasma. The highest concentrations were observed in the area near where the ring was placed (mean C_{max}: 79.9 µg/g; median T_{max}: Day 3), followed by the cervix (mean C_{max}: 66.6 µg/g; median T_{max}: Day 4). Dapivirine vaginal fluid concentrations were well above the reported *in vitro* IC₅₀ (50% inhibitory concentration for virus replication) of 0.3 ng/mL in MT4 T cells and the concentration at which greater than 99% inhibition of integrated provirus was observed (3.3 ng/mL) in cervical tissue. On Day 28, prior to ring removal, the mean concentrations (C_{pre-ring removal}) were 38.6 µg/g, 35.8 µg/g and 13.3 µg/g in the area of the ring, in the cervix and near the introitus, respectively.¹⁸

By Day 56 (final visit), the plasma dapivirine concentrations of all participants but one were below the LLOQ (3.00 pg/mL) and in all participants vaginal fluid levels were below the LLOQ.

IPM 013 was a Phase 1, randomized, double-blind, placebo-controlled trial conducted over three months in 48 healthy, HIV-negative, sexually active women, 18 to 40 years of age in Belgium. This trial evaluated the delivery of dapivirine from a matrix (platinum-catalyzed) ring and assessed local and systemic safety. Participants were randomized (3:1) to either active or placebo ring. Two groups completed the trial with varying lengths of use. The VR was removed on Day 28, and a new ring was inserted on Day 31 for 28 days in Group A. In Group B, the initial ring was removed on Day 35 and a new ring was inserted on Day 38 for 21 days. Group B had a third ring inserted on Day 59, this ring was worn for 24 hours.

Compared to vaginal fluids, systemic exposure to dapivirine in plasma was low. Plasma concentrations did not exceed 553 pg/mL, while the highest vaginal fluid concentration obtained was 171 µg/g. Data suggest that dapivirine is readily released from the ring and absorbed into the surrounding tissue and into the bloodstream in concentrations. Concentrations of dapivirine collected within 4 hours of ring insertion show quantifiable plasma (LLOQ = 3.00 pg/mL) and vaginal fluid (LLOQ = 0.4 ng) after insertion of the first ring.

Other Vaginal Dapivirine Formulations

Dapivirine Gels 4759 and 4789

Gels 4759 and 4789 are being tested in IPM 020 and IPM 014A.¹⁴ IPM 020 is a double-blind, randomized, placebo-controlled Phase 1/2 expanded safety study involving approximately 180 healthy, sexually active HIV-uninfected women to assess the safety of Dapivirine Gel 4759, 0.05% 2.5g and Dapivirine Gel 4789, 0.05% 2.5g as compared to the HEC-based Universal Placebo gel. As of June 2011, data for this study was currently under analysis. IPM 014A is a double-blind, randomized, placebo-controlled Phase 1/2 Study to Evaluate the Safety and Acceptability of Dapivirine Gel 4759, 0.05%, 2.5g, conducted using daily monitored adherence in 320 healthy, HIV-uninfected women to determine whether the gel is safe for daily use by women in Kenya, Malawi, Rwanda, South Africa and Tanzania. As of June 2011, this study was currently ongoing.

Dapivirine Gel 4750

Gel 4750 was studied in IPM 012. Gel 4750 included excipient Vitamin E TPGS (dispersing agent, 0.50%); otherwise the gel formulations (Gel 4750 and Gel 4759) were essentially the same.¹⁴ In IPM 012, the safety and pharmacokinetics of two formulations of dapivirine vaginal gel were compared with the HEC-based Universal Placebo gel in 36 healthy, HIV-uninfected, sexually abstinent women 18 to 40 years of age. This Phase 1, randomized, double-blind, placebo-controlled trial was conducted at one research center in Belgium. Women were randomized in a 1:1:1 ratio to once daily (QD) applications of Gel 4750 (0.05%, 2.5 g), Gel 4789 (0.05%, 2.5 g), or placebo gel

for 11 days (Day 1 followed by a 3-day washout period and then for 10 consecutive days, Days 5-14). Dapivirine concentrations were measured in cervicovaginal fluids and plasma on Days 1, 2, 5, 9, 11, 14-17, 19, 21, and 24.

Systemic absorption of dapivirine was low. C_{max} and AUC_{0-24h} values for dapivirine in plasma were slightly higher for Gel 4750 than Gel 4789 on Days 1 and 14; however, the differences did not achieve statistical significance. For both gels, Day 14 values were 2- to 4-fold higher than values on Day 1. T_{max} was variable; on Day 1 the mean was 23.5 hours for both gels, whereas by Day 14 means were 10-12 hours. Terminal half-life was much longer in plasma (73-90 hours) than in cervicovaginal fluids (15-17 hours).²¹

Safety

Clinical Trials of Dapivirine Vaginal Rings

Table 1: Clinical Phase I/II of Dapivirine Vaginal Rings

Trial Details			Number of Participants				
Trial Number	Description	Country	Ring-001 reservoir (200 mg)	Ring-002 reservoir (25 mg)	Ring-003 matrix* (25 mg)	Ring-004 matrix** (25 mg)	Placebo Ring
IPM 001	Safety and PK in women; 7 days	Belgium	12	--	--	--	12 (crossover)
IPM 008	Safety and PK in women; 7 days	Belgium	--	10	--	--	3
IPM 013	Safety and PK in women; 56/57 days	Belgium	--	--	--	36	12
IPM 015 [#]	Safety and PK in women; 84 days	Africa	--	--	--	140	140
IPM 018	Safety and PK in women; 28 days	Belgium	--	8	8	--	8
IPM 024	Safety and PK in women; 28 days	Belgium	--	--	--	8	8
TOTAL 393 participants:			12	18	8	184	183

* Tin-catalysed matrix ring.

** Platinum-catalysed matrix ring.

[#] Data analysis ongoing; results pending.

Across all clinical trials with multiple ring configurations in healthy participants, the dapivirine VR was generally safe and well tolerated.¹⁸ No serious adverse events (SAEs) were reported in participants using the VR. One participant using the placebo ring experienced two SAEs, bacterial gastroenteritis and pyrexia, which were assessed by the investigator as unrelated to the investigational product. No participants were discontinued from the VR due to investigational product-related adverse events (AEs). The first dapivirine VR tested in humans, Ring-001, consisted of two reservoir cores of dapivirine surrounded by a controlled-release outer sheath of silicone elastomer. Ring-001 was tested in a Phase 1, open-label, crossover trial in 12 healthy, sexually abstinent, HIV-uninfected women at a single research center in Belgium (IPM 001).¹¹ Women used the placebo ring for 7 days followed by the dapivirine ring for 7 days. There were no SAEs during the trial and few treatment-emergent adverse events (TEAEs). The dapivirine ring was considered to be safe based on the results of this trial in healthy participants.

Ring-002, a similar formulation with a single dapivirine reservoir core, was used in a later clinical trial. Ring-002 was tested in a Phase 1, randomized, placebo-controlled trial conducted at a single research center in Belgium (IPM 008).¹¹ Ten women underwent 7-day exposure to dapivirine Ring-002, and three women used a placebo ring for 7 days. There were no SAEs during the trial and few TEAEs. The trial results showed that the dapivirine ring was safe in healthy participants.

Ring-003, a dapivirine matrix VR containing 25 mg of drug substance dispersed in a tin-catalyzed-cured silicone matrix, was compared with Ring-002 in a Phase 1, randomized, placebo-controlled trial conducted at a single research center in Belgium. Twenty-four healthy, HIV-uninfected women 18 to 35 years of age were randomly assigned (1:1:1) to dapivirine matrix ring, dapivirine reservoir ring, or placebo ring for 28 consecutive days. No SAEs were reported during the study. No TEAEs were assessed by the investigator as definitely or probably related to the ring, and similar percentages of participants in the dapivirine and placebo ring groups had TEAEs considered to be possibly related to the ring.

The current formulation, Ring-004, is a dapivirine matrix VR containing 25 mg of drug substance dispersed in a platinum-catalyzed-cured silicone matrix. Ring 004 was tested in a 28-day trial (IPM 024) conducted in Belgium, involving 16 healthy, HIV-uninfected, sexually abstinent women, between 18 to 40 years of age. The women were randomly assigned to a dapivirine (25 mg) matrix ring or a placebo ring for 28 consecutive days. No SAEs were reported in the dapivirine VR group. No AEs assessed by the investigator were judged to be related to the study agent. Most dapivirine VR group participants, 87.5% (7/8), experienced at least one TEAE. Of the women in the dapivirine VR group who experienced a TEAE, 50% (4/8) reported headache. Two to four women (25% to 50%) with dapivirine VRs experienced Grade 1 or Grade 2 metrorrhagia, vulvovaginal discomfort and nasopharyngitis TEAEs. One participant experienced a Grade 1 vaginal hemorrhage in the dapivirine VR group.¹⁸

Clinical Trials of Other Vaginal Dapivirine Formulations

Dapivirine Gel 001

Dapivirine gel was tested in a 2-part, Phase 1 trial (TMC120-C127) in 48 HIV-uninfected women and 16 HIV-positive women.¹⁴ Twice-daily application of one of three concentrations of Gel-001 (0.0008%, 0.0016%, or 0.0049%) or a placebo gel was investigated. There were no apparent differences in safety parameters between the three concentrations of Gel-001 and the placebo gel, nor were there apparent safety differences between sexually active and sexually abstinent women. Dapivirine concentrations in plasma remained essentially level in all three dose groups after maximum concentrations were reached 4 to 8 hours after gel application. The vaginal gels were well-tolerated by healthy participants and HIV-positive participants.¹⁵

Dapivirine Gel 002

To improve solubility and stability, a new vehicle was developed for vaginal delivery of dapivirine.¹⁴ This new gel was tested in three Phase 1/2 trials: IPM 003, IPM 004 and IPM 005B. In IPM 003, conducted in South Africa, Rwanda, and Tanzania, 112 women used one of three concentrations of dapivirine gel or a placebo gel for 42 days.¹² In IPM 004, a pharmacokinetics trial conducted in South Africa, 18 women used one of three concentrations of dapivirine gel for 10 days. In IPM 005B, conducted in Belgium, 36 women used dapivirine gel (0.02%, 2.65 g) or Universal Placebo gel for 42 days. No treatment related SAEs were observed in these studies. In general, dapivirine gel was well-tolerated with no safety concerns or dropouts due to investigational product-related AEs.

Dapivirine Gels 4750 and 4789

The pharmacokinetics of candidates Gel 4750 and Gel 4789 (both 0.05%, 2.5 g) were tested in IPM 012, which was conducted in Belgium in 36 women who applied the vaginal gel QD for 11 days.¹⁴ There were no SAEs or discontinuations due to TEAEs in the trial. Most participants (83-100%) in each group had at least one TEAE during the trial. Headache was the event that occurred most often; 42-67% of participants in the dapivirine gel groups and 42% of participants in the placebo gel group reported at least one headache. For most participants with headaches (13/18; 72%), the event was assessed as possibly related to the investigational product.

All but two TEAEs were assessed as Grade 1 (mild). One subject in the Gel 4789 group had a Grade 2 (moderate) headache assessed as possibly related to the investigational product, and a different subject in the same group had Grade 2 pyrexia assessed as not related to the investigational product. Thirty-four percent (36/105) of TEAEs were assessed as possibly related to the investigational product, and one subject in the Gel 4789 group had two episodes of vulvovaginal pruritus that were assessed as probably related. Among participants using Gel 4750, the other TEAEs deemed related to the gel included malaise (1/12) and cervix erythema (1/12).

IPM 014B examined the safety of once daily application of Gel 4789 (0.05% dapivirine) over a six-week period as compared with a matching vehicle placebo gel in a Phase I/2, randomized, double-blind, placebo-controlled trial in 100 healthy, sexually active, HIV-negative women at three sites in South Africa. Women were randomized 1:1 to once daily vaginal application of Gel 4789 or placebo gel for 42 days. No SAEs or discontinuations due to TEAEs were reported during the trial.

Most participants reported at least one TEAE during the trial, none of which was assessed as definitely related to gel use. Eighteen (36%) of participants in the dapivirine gel group and 13 (26%) of participants in the placebo gel group experienced TEAEs considered to be probably or possibly related to the gel. All TEAEs were assessed as Grade 1 or Grade 2, with the exception of a grand mal convulsion, experienced by a study participant in the placebo arm. This participant had been enrolled in error, having had a history of epilepsy. Metrorrhagia was the AE reported most frequently (11 of 100 study participants; 7 of 50 randomized to placebo gel and 4 of 50 randomized to dapivirine gel). All were reported as mild (Grade 1) intermenstrual or breakthrough menstrual bleeding, and for 62% of the women for whom metrorrhagia was reported, it was thought to be unrelated to study product. Events that occurred in more than one participant and were thought to be possibly or probably related to dapivirine gel included bacterial vaginitis, headache, vaginal candidiasis, urinary tract infection, vulvovaginal mycotic infection, vaginal discharge and vulvovaginal pruritus. In the placebo gel arm, bacterial vaginitis, headache, vaginal candidiasis, and vulvovaginal mycotic infection were considered to be related to placebo gel.

Two studies of dapivirine gel have results pending, IPM 014A is a study examining the safety and acceptability study of Gel 4759 in 280 HIV-negative women (once daily gel application for 42 days), and IPM 020 is an expanded safety trial of once daily application of two formulations of dapivirine gel (Gel 4759 or Gel 4789) as compared with placebo for 84 days in 128 women.

In addition to the safety acceptability and PK studies noted above, a male tolerance study of dapivirine gel (Gel 4759), MTN-012/IPM 010, is underway with results expected to be available in the fourth quarter of 2011. Forty-eight males (24 circumcised and 24 uncircumcised) were enrolled into this Phase 1 study which will provide valuable information regarding tolerability after 7 days of once-daily penile application of dapivirine gel.

Oral Dapivirine

There have been 11 oral administration trials in which a total of 211 participants have been dosed with dapivirine. The maximum tolerated dose established was 350 mg for a single dose, and for multiple doses, 300 mg twice a day for 14 days. There were no deaths during clinical trials of oral dapivirine, and no trials were stopped for safety reasons. A total of 10 participants stopped dapivirine treatment prior to trial completion for safety reasons, six of whom stopped due to a clear dose dependent increase in central nervous system (CNS) and gastrointestinal TEAEs, thereby establishing the maximum tolerated dose at 300 mg twice a day. These TEAEs resolved within 1-2 days

after discontinuation of use of oral dapivirine. One of the discontinuations was classified as an SAE, with hospitalization due to elevated liver function tests. This participant was also infected with hepatitis C virus. The only other SAE noted in these trials was a hospitalization due to a bicycle accident.

Pregnancy Outcomes

There are no adequate and well-controlled studies of dapivirine in pregnant women.

In conclusion, these reassuring safety data and promising anti-HIV-1 activity data from 25 Phase 1 and Phase 1/2 clinical trials make dapivirine an ideal candidate for a Phase 3 safety and effectiveness clinical trial.¹⁴

2.6.2 Clinical Studies of Placebo VR

Similar placebo VRs were studied in IPM 024.

2.7 Study Hypothesis and Rationale for Study Design

2.7.1 Study Hypothesis

Safety Profile

The protocol team hypothesizes that the active study product will be safe, well-tolerated and acceptable for extended use among healthy sexually-active women.

Effectiveness

The null hypothesis is that the active product will be no more than 25% effective. The trial is powered to detect at least 60% effectiveness in preventing acquisition of HIV-1 relative to placebo, and to rule out effectiveness of 25% or lower.

2.7.2 Rationale for Study Design

Based on *in vitro*, *in vivo*, and *ex vivo* studies described in the Dapivirine VR IB, dapivirine shows great promise as a topical microbicide to prevent HIV-1 infection.¹⁷

Vaginal rings have already been developed and approved as delivery methods for medications. For example, NuvaRing® a contraceptive VR made of the copolymer evatane, in which 2.7 mg of ethinyl estradiol (EE) and 11.7 mg of etonogestrel (ENG) are equally dispersed, has been found to be both effective and acceptable.²² In an acceptability study involving 1,950 NuvaRing® users, 45.5% of women cited their reason for liking the VR was “not having to remember anything.”²³ These contraceptive ring data are encouraging as microbicide ring effectiveness correlates with consistent and correct use. It is likely that products that can be applied less frequently will be more acceptable to users, achieve better user-adherence, and may lead to increased effectiveness. Vaginal rings that need only be replaced every 28 days may have benefits over dosage forms that need to be used more frequently as well as offer a wider choice of microbicide formulations for women if proven effective.

Pfizer (formerly Pharmacia and Upjohn Company) has marketed Estring[®] (estradiol vaginal ring), a VR that is also made from silicone elastomer and contains estradiol used to treat local symptoms of urogenital atrophy, since 1993. Prior to the launch of Estring[®], the biological safety of the silicone elastomer was studied in various *in vitro* and *in vivo* test models. The results show that the silicone elastomer is non-toxic, non-pyrogenic, non-irritating, and non-sensitizing.²⁴

Femring[®] (estradiol acetate vaginal ring), a hormone replacement product approved in June 2003 by the United States (U.S.) Food and Drug Administration (FDA) treats menopause-induced vasomotor symptoms (e.g., hot flushes) and symptoms of vulvar and vaginal atrophy (e.g., dryness).²⁵ Although these rings are not exactly the same as the IPM ring, the extensive clinical trial and post-marketing experience gained from these products provides further assurance of the safety of silicone elastomer rings as vaginal drug delivery devices. An acceptability trial of the silicone elastomer ring used in Femring[®] (but containing no drug) among postmenopausal women in the U.S. demonstrated very high acceptability and ease of use.²⁶ IPM recently evaluated the acceptability and safety of a similar placebo VR in the IPM 011 study (n=170).²⁵ This study confirmed that the placebo ring was safe and acceptable to users and their male partners.

MTN-020, A Study to Prevent Infection with a Ring for Extended Use (ASPIRE) has been developed to compare the safety and effectiveness of dapivirine (25 mg) in a silicone elastomer vaginal matrix ring (Ring-004) with a placebo VR when inserted once every 28 days for the prevention of HIV-1 infection in healthy, HIV-uninfected sexually active women.

2.7.3 Incorporating Emergent Effective HIV-1 Prevention Strategies

As candidate microbicides continue to demonstrate evidence of efficacy, the potential for one or more licensed HIV-1 prevention strategies may soon become a reality. The ASPIRE Protocol Team acknowledges that an effective agent may require changes to the current protocol design. The team plans to follow all relevant national policies regarding HIV-1 prevention and will actively consult with stakeholders in the event an effective intervention is approved. Consultation with target populations, policy makers, governments and other stakeholders will be ongoing throughout the duration of study implementation and participant follow-up by study leadership, Microbicide Trial Network (MTN) Leadership and the MTN Community Work Group (CWG).

3 OBJECTIVES

3.1 Primary Objectives

- To determine the *effectiveness* of dapivirine (25 mg) administered in a silicone elastomer vaginal matrix ring, when inserted once every 4 weeks, in preventing HIV-1 infection among healthy sexually active HIV-uninfected women
- To assess the *safety* of dapivirine (25 mg) administered in a silicone elastomer vaginal matrix ring, when inserted once every 4 weeks over the investigational product use period

3.2 Secondary Objectives

- To evaluate the *acceptability* of the study VR (dapivirine or placebo) in HIV-uninfected women, when inserted once every 4 weeks over the investigational product use period.
- To evaluate the *adherence* to the study VR (dapivirine or placebo) in HIV-uninfected women, when inserted once every 4 weeks over the investigational product use period.
- To assess the frequency of HIV-1 *drug resistance* in women who acquire HIV-1 infection while using the investigational product
- To evaluate the *relationship between drug concentration and HIV-1 seroconversion*.

3.3 Exploratory Objectives

- Describe changes in the *genital microenvironment*
- To assess *correlation of steady-state drug concentration and adherence measures*
- To assess the *incidence of HIV-1 seroconversion* during 4 weeks off study product, between the PUEV and termination visit.

4 STUDY DESIGN

4.1 Identification of Study Design

ASPIRE is a multi-site, double-blind, randomized, placebo-controlled Phase 3 trial to evaluate the safety and effectiveness of dapivirine (25 mg) in a silicone elastomer

vaginal matrix ring, inserted once every 4 weeks for the prevention of HIV-1 infection in healthy, sexually active HIV-uninfected women, when compared to a placebo VR.

4.2 Summary of Major Endpoints

- **Effectiveness**
 - HIV-1 infection as measured by seroconversion at the end of the investigational product use period with seroconversion defined by the algorithm in Appendix III
- **Safety**
 - Grade 2 AEs, judged to be related to study product
 - Grade 3 and 4 AEs
 - All serious adverse events

4.3 Description of Study Population

Approximately 3476 sexually active HIV-uninfected women 18-45 years of age who meet eligibility criteria as described in Sections 5.2 and 5.3 will be enrolled and randomized in a 1:1 ratio to receive either a silicone elastomer vaginal matrix ring containing 25 mg of dapivirine or a placebo VR.

4.4 Time to Complete Accrual

Accrual is expected to be completed in approximately 12 months.

4.5 Study Groups

Two study groups are planned. The two study groups are as follows:

- 1) Dapivirine VR group
- 2) Placebo VR group

4.6 Expected Duration of Participation

Each participant will engage in the screening process for up to 4 weeks (28 days) prior to enrollment and will use the product until 120 events (HIV-1 seroconversions) are observed in the trial. Based on the anticipated rate of accrual of participants and projected HIV-1 incidence in the trial, it is expected that 120 events will be reached approximately 12 months after the last participant enrolls, and thus all participants are anticipated to have a minimum of 12 months on study product. Each participant will complete approximately 4 additional weeks of follow-up off study product to assess for potential delayed seroconversions due to masked infections that are not detected during the product use period.

4.7 Sites

Sites selected by the MTN Executive Committee will participate in ASPIRE.

5 STUDY POPULATION

5.1 Selection of the Study Population

The inclusion and exclusion criteria in Sections 5.2 and 5.3 are used to ensure the appropriate selection of study participants.

5.1.1 Recruitment

Participants are recruited from a variety of sources across sites, including sexually transmitted disease (STD) clinics, family planning clinics, and post-natal clinics, as well as community-based locations. In addition, participants may be referred to the study from other local research projects and other health and social service providers serving the target study population. Recruitment materials are approved by site Institutional Review Boards/Ethics Committees (IRBs/ECs) prior to use. Advice regarding these materials will be sought from site community representatives before they are submitted to the IRB/EC for review.

5.1.2 Retention

Once a participant is enrolled/randomized in ASPIRE, the study site makes every effort to retain her in follow-up to minimize possible bias associated with loss-to-follow-up. Standard operating procedures (SOPs) for participant retention to target loss-to-follow-up rates that do not exceed the incidence rate of the primary study endpoint are required of each site. As such, an average annual retention rate of 95% is targeted across sites. All study sites are responsible for developing and implementing local SOPs to achieve this. Components of such procedures may include the following:

- Thorough explanation of the study visit schedule and procedural requirements during the informed consent process, and re-emphasis at each study visit. Also as part of the informed consent process, encouragement of participants to discuss potential study participation with their husbands/partners and other influential family members.
- Thorough explanation of the importance of both study groups to the overall success of the study.
- Collection of detailed locator information at the study screening visits, and active review and updating of this information at each subsequent visit.
- Use of mapping techniques to establish the location of participant residences and other locator venues.

- Use of appropriate and timely visit reminder mechanisms.
- Immediate and multifaceted follow-up on missed visits, including the allowance of off-site visits.
- Mobilization of trained outreach workers to complete in-person contact with participants at their homes and/or other locations.
- Regular communication with the study community at large to increase awareness of HIV/AIDS and explain the purpose of HIV prevention research and the importance of completing research study visits.

Study sites may use a participant tracking database to facilitate visit scheduling and timely identification and follow-up on missed visits. The MTN Statistical Data Management Center (SDMC) generates monthly reports on the number and percentage of participants completing follow-up visits throughout the course of the study. The protocol team, as well as the MTN Study Monitoring Committee (SMC), track retention rates closely and work with study sites as needed to take any required action to address below-target retention rates.

5.2 Inclusion Criteria

Women must meet all of the following criteria to be eligible for inclusion in the study:

- 1) Age 18 through 45 years (inclusive) at screening, verified per site SOPs; within this range, sites may restrict the upper age limit per site SOPs, to target women at high risk of HIV infection
- 2) Able and willing to provide written informed consent to be screened for and to take part in the study
- 3) Able and willing to provide adequate locator information, as defined in site SOPs
- 4) HIV-uninfected based on testing performed by study staff at screening and enrollment (per applicable algorithm in Appendix II)
- 5) Per participant report, sexually active, defined as having vaginal intercourse at least once in the 3 months prior to screening
- 6) Using an effective method of contraception at enrollment, and intending to use an effective method for the duration of study participation; effective methods include hormonal methods (except contraceptive ring); intrauterine device (IUD); and sterilization (of participant, as defined in site SOPs)
- 7) At screening and enrollment, agrees not to participate in other research studies involving drugs, medical devices, vaginal products, or vaccines for the duration of study participation

Note: Tampons may be used for the duration of the trial.

5.3 Exclusion Criteria

Women who meet any of the following criteria will be excluded from the study:

- 1) Per participant report at screening:
 - a) Intends to become pregnant during study participation
 - b) Plans to relocate away from the study site during study participation
 - c) Plans to travel away from the study site for more than 8 consecutive weeks during study participation

- 2) Is pregnant

Note: A documented negative pregnancy test performed by study staff is required for inclusion; however a self-reported pregnancy is adequate for exclusion from the study.

- 3) Currently breastfeeding

- 4) Diagnosed with urinary tract infection (UTI)

Note: Otherwise eligible participants diagnosed with UTI during screening are offered treatment and may be enrolled after completing treatment and all symptoms have resolved. If treatment is completed and symptoms have resolved within 28 days of obtaining informed consent for screening, the participant may be enrolled.

- 5) Diagnosed with pelvic inflammatory disease, an STI or reproductive tract infection (RTI) requiring treatment per current WHO guidelines

Note: Otherwise eligible participants diagnosed during screening with pelvic inflammatory disease or STI/RTI requiring treatment per WHO guidelines — other than asymptomatic BV and asymptomatic candidiasis — are offered treatment and may be enrolled after completing treatment and all symptoms have resolved. If treatment is completed and symptoms have resolved within 28 days of obtaining informed consent for screening, the participant may be enrolled. Genital warts requiring treatment also must be treated prior to enrollment. Genital warts requiring therapy are defined as those that cause undue burden or discomfort to the participant, including bulky size, unacceptable appearance, or physical discomfort.

- 6) Has a clinically apparent Grade 2 or higher pelvic exam finding (observed by study staff) as per the Division of AIDS Table for Grading the Severity of Adult and Pediatric Adverse Events Version 1.0, December, 2004 (Clarification dated August 2009), Addendum 1-Female Genital Grading Table for Use in Microbicide Studies

Note: Cervical bleeding associated with speculum insertion and/or specimen collection judged to be within the range of normal according to the clinical judgment of the Investigator of Record (IoR)/designee is considered expected non-menstrual bleeding and is not exclusionary.

Note: Otherwise eligible participants with exclusionary pelvic exam findings may be enrolled/randomized after the findings have improved to a non-exclusionary severity grading or resolved. If improvement to a non-exclusionary grade or resolution is documented within 28 days of providing informed consent for screening, the participant may be enrolled.

- 7) Participant report and/or clinical evidence of any of the following:
- a) Known adverse reaction to any of the study products (ever)
 - b) Known adverse reaction to latex (ever)
 - c) Chronic vaginal candidiasis
 - d) Non-therapeutic injection drug use in the 12 months prior to Screening
 - e) Post-exposure prophylaxis (PEP) for HIV exposure within 6 months prior to enrollment
 - f) Last pregnancy outcome 90 days or less prior to enrollment
 - g) Gynecologic or genital procedure (e.g., tubal ligation, dilation and curettage, piercing) 90 days or less prior to enrollment
 - h) Recent participation in any other research study involving drugs, medical devices, vaginal products, or vaccines, within 60 days of enrollment
 - i) Participation in the MTN-003, Vaginal and Oral Interventions to Control the Epidemic (VOICE) clinical trial, or any other HIV prevention study using systemic or topical antiretroviral medications, within 12 months of enrollment
 - j) As determined by the IoR/designee, any significant uncontrolled active or chronic cardiovascular, renal, liver, hematologic, neurologic, gastrointestinal, psychiatric, endocrine, respiratory, immunologic disorder or infectious disease, including active tuberculosis
- 8) Has any of the following laboratory abnormalities at Screening Visit:
- a) Aspartate aminotransferase (AST) or alanine transaminase (ALT) Grade 1 or higher as per the Division of AIDS Table for Grading the Severity of Adult and Pediatric Adverse Events Version 1.0, December, 2004 (Clarification dated August 2009)
 - b) Creatinine Grade 2 or higher as per the Division of AIDS Table for Grading the Severity of Adult and Pediatric Adverse Events Version 1.0, December, 2004 (Clarification dated August 2009)
 - c) Hemoglobin Grade 2 or higher as per the Division of AIDS Table for Grading the Severity of Adult and Pediatric Adverse Events Version 1.0, December, 2004 (Clarification dated August 2009)
 - d) Platelet count Grade 1 or higher as per the Division of AIDS Table for Grading the Severity of Adult and Pediatric Adverse Events Version 1.0, December, 2004 (Clarification dated August 2009)
 - e) Pap result Grade 2 or higher according to the Female Genital Grading Table for Use in Microbicide Studies Addendum 1 to the DAIDS Table for Grading Adult and Pediatric Adverse Events, Version 1.0, December 2004 (Clarification dated August 2009)

Note: Otherwise eligible participants with an exclusionary test may be re-tested during the screening process.

Note: Women with a documented normal result within the 12 months prior to enrollment need not have Pap smear during the screening period. Women with a Grade 1 abnormal Pap smear can be enrolled upon completion of the initial phase of evaluation if no current treatment is indicated (based on local standard of care for management of abnormal cervical cytology). Need for a repeat Pap within 6 months does not preclude enrollment prior to that result becoming available.

- 9) Has any other condition that, in the opinion of the IoR/designee, would preclude informed consent, make study participation unsafe, complicate interpretation of study outcome data, or otherwise interfere with achieving the study objectives

5.4 Co-enrollment Guidelines

As indicated in Section 5.2, participants should not take part in other research studies involving drugs, medical devices, vaginal products or vaccines after the Screening Visit and while taking part in this study. Each site will be responsible for defining procedures for management and prevention of co-enrollment prior to initiation.

Exceptions to this guideline may be made for participants to coenroll in the following types of studies at the discretion of the IoR/designee:

- Participants may take part in ancillary studies approved by MTN-020 Protocol Chair
- Participants who become infected with HIV may take part in observational and/or interventional studies for HIV-positive persons
- Participants who become pregnant may take part in observational studies, including pregnancy registries approved by MTN-020 Protocol Chair

Should any participant report or should study staff discover concurrent participation in contraindicated studies after enrolling in MTN-020, the IoR/designee will consult the Protocol Safety Review Team (PSRT) regarding ongoing product use and other potential safety considerations associated with co-enrollment.

6 STUDY PRODUCT

6.1 Regimen

Each participant will be randomized to one of two study regimens:

Table 2: Study Regimen

Group	N	Group Description
A	1738	Dapivirine VR, containing 25 mg dapivirine
B	1738	Placebo VR

Each participant will receive a VR containing either 25 mg dapivirine or a placebo VR in a 1:1 ratio. The VR should be worn for approximately 28 consecutive days at a time but not more than 35 days before being replaced. A new VR will be inserted into the vagina at the Enrollment Visit and at each subsequent monthly visit. The previously inserted ring will be removed by the participant or clinician/designee at each monthly visit. The participant will be followed for approximately 4 weeks following the final VR removal.

6.2 Administration

The participant will self-insert (or by clinician, if necessary), the study VR at the Enrollment Visit and each subsequent visit when a VR is dispensed. In the rare event that a participant is unable to attend their next scheduled visit, IoRs may use their discretion to dispense a maximum of one additional ring. In this situation, the participant will insert the ring at home.

Study participants will be given detailed instructions in the clinic on proper VR insertion and removal procedures at the Enrollment Visit and as needed at subsequent visits. Hands should be thoroughly washed before and after study VR insertion and/or removal. The attempt of these procedures should be documented at Enrollment. Additional details on administration (ring insertion, removal, procedures in the event of expulsion or loss) will be provided in the ASPIRE Study Specific Procedures (SSP) Manual.

6.3 Study Product Formulation

The study VR is an off-white, flexible ring containing either 25 mg of dapivirine or no drug (placebo) dispersed in a platinum-catalyzed-cured silicone matrix. The ring dimensions are as follows: 56 mm and 7.7 mm, outer diameter and cross-sectional diameter, respectively. The ring is designed to provide sustained release of drug over a 28-day period.

6.3.1 Dapivirine VR

Dapivirine 0.3125% (w/w) is dispersed in a flexible, opaque, cured silicone VR delivery device. The VR will contain 25 mg of dapivirine. The dapivirine VR should be stored at 15°C to 30°C.

6.3.2 Placebo VR

The placebo VR is manufactured with the same components as the drug-containing rings, except that it contains USP titanium dioxide dispersed in the silicone fluid as colorant, and no active pharmaceutical ingredient. The purpose of the colorant is for maintaining blinded conditions. The placebo VR should be stored at 15°C to 30°C.

6.4 Supply and Accountability

6.4.1 Supply

IPM (Silver Spring, MD) will oversee the manufacture all of the study VRs and analyze/release the rings under Good Manufacturing Practices (GMP).

6.4.2 Study Product Dispensing

Study VRs are dispensed only to enrolled study participants or clinic staff on behalf of the participant, upon receipt of a written prescription from an authorized prescriber. Dispensing takes place on the day of enrollment and at each scheduled follow-up visit, except at the Product Use End Visit and Study Exit/Termination Visit. If the participant is unable to attend their next scheduled visit it is up to the discretion of the IoR to provide an additional ring. Under special circumstances, more than two rings may be dispensed after consultation with the DAIDS MO. All such circumstances must be documented fully by the IoR/designee as described in the ASPIRE SSP Manual.

6.4.3 Accountability

Each CRS Pharmacist of Record (PoR) is required to maintain complete records of all study products received from the NIAID Clinical Research Products Management Center (CRPMC) and subsequently dispensed. All unused study products must be returned to the MTN Pharmacist after the study is completed or terminated unless otherwise instructed by the MTN Pharmacist. The procedures to be followed are provided in the MTN-020 Pharmacy Manual

All study product dispensed to a participant must be documented by the clinic staff when it is returned. This includes a ring that is brought back to the clinic by the participant and any ring removed at the clinic visit. Any study products not returned must also be documented by the clinic.

6.4.4 Retrieval of Study Product

As per Section 8, study product use for a participant may be temporarily held or permanently discontinued. Study product must be retrieved (optimally within 24 hours) and returned to the clinic when product use is permanently discontinued for HIV seroconversion (see table below). Additional study product retrieval specifications in response to product holds, discontinuations for other reasons, or IoR instruction, can be found in the table below. Study product retrieval may occur either by the participant returning the VR (used and unused) to study staff within the specified timeframe or by study staff conducting outreach to retrieve the product from the participant (e.g., at her home).

Table 3: Retrieval of Study Product

	Retrieve Study Product
Permanent discontinuation or temporary hold due to potential HIV seroconversion	Within 24 hours
Permanent discontinuation due to severe (Grade 3 or higher) renal or hepatic toxicity	Within 5 working days
Permanent discontinuation for any other reason	Within 5 working days
IoR discretion	Within 5 working days
Temporary hold due to pregnancy	Within 5 working days
Temporary hold for reasons other than pregnancy with expected duration of at least 7 days	Within 7 working days

In addition to the specifications listed above, under any circumstances, if product hold extends for 7 days or more, and product has not been retrieved as of the seventh day, study staff members must make every effort to retrieve all study product within 7 additional working days.

It is not necessary to retrieve study products from participants for whom study product use is being temporarily held for less than 7 days. However, study products may be retrieved from such participants, to protect their safety, if there is concern that the participant may not comply with clinic staff instructions to refrain from study product use for the duration of the temporary hold. For all study product holds requiring retrieval of study product(s), if the study product(s) are not retrieved within timeframe stated in table above, the MTN-020 PSRT must be informed.

If prolonged use (greater than 35 days) of the study VR has occurred, the product must be retrieved.

For each participant, all VRs remaining in the participant's possession should be retrieved at the Study Exit/Termination Visit. If the participant does not bring her remaining supplies to this visit, study staff must arrange to retrieve the VR within 2 business days. If the study product(s) are not retrieved within that timeframe, the MTN-020 PSRT must be informed.

The PoR will document all unused product returns and store returned study products in designated areas within the study pharmacy.

6.5 Adherence Counseling and Assessment

Counseling

Participants will receive study VR adherence counseling and product use instructions at the Enrollment Visit and at additional follow-up visits, as needed. Site staff will counsel participants in VR product use; including, to refrain from removing the ring (except as directed), and instructions for re-insertion in case of accidental ring expulsion, etc. Participants will also be discouraged from using intravaginal medications and practices as described in Section 6.7.

An Adherence Strengthening Approach, similar to that developed for the VOICE trial, will be adapted for ASPIRE.

Assessment

Participant behaviors regarding study VR use will be collected via standardized questions developed by the protocol team in conjunction with study site staff and community representatives, to maximize the accuracy of self-reported data. Assessment of participant adherence will be evaluated using a quantitative instrument.

6.6 Concomitant Medications

Enrolled study participants may use concomitant medications during study participation. All concomitant medications as well as illicit substances reported throughout the course of the study will be recorded on case report forms designated for that purpose. All prescription medications, over-the-counter preparations, vitamins, nutritional supplements, and herbal preparations will be recorded on forms for concomitant medications.

Concomitant medications that either inhibit or induce CYP450 enzymes will be permitted. Systemic exposure to dapivirine observed in women following use of dapivirine gel is very low. The low absorption of dapivirine indicates that the transcutaneous absorption would be lower still. Therefore, there is not expected to be a significant change in the dapivirine concentration with concomitant use of CYP450 (including CYP3A4) inducers or inhibitors. The low systemic exposure to dapivirine also suggests that it is very unlikely to induce the metabolism of other co-administered drugs.

6.7 Use of Intravaginal Medications and Practices

Concomitant use of non-study vaginal products, practices or use of other devices including but not limited to spermicides, diaphragms, contraceptive VRs, vaginally applied medication, menstrual cups, cervical caps, douches, lubricants, etc., will be discouraged. Participants will be instructed to avoid these medications and practices in

order to protect the integrity of the lower genital tract and reduce the possibility of AEs due to agents other than the study ring and product.

7 STUDY PROCEDURES

An overview of the study visit and evaluations schedule is provided in Appendix I. Follow-up study visits may take place either on-site, in a participant's home, or at other community-based locations, depending on site capacity and site/participant preference. If genital symptoms are reported during an off-site visit, the participant is instructed to report to the on-site clinic as soon as possible for a pelvic exam. Presented in this section is additional information on visit-specific study procedures. Detailed instructions to guide and standardize procedures across sites (including the conduct of off-site study visits) are provided in the ASPIRE Study Specific Procedures (SSP) Manual available at www.mtnstopshiv.org.

7.1 Pre-Screening

As part of participant outreach and recruitment strategies, study staff may pre-screen potential study participants either on-site or at off-site locations. During these interactions, study staff may explain the study to potential participants and ascertain elements of presumptive eligibility, to be confirmed at on-site screening visits. Process information (e.g., number of potential participants contacted, number presumptively eligible) may be recorded and stored at the study site in the absence of written informed consent from potential participants, provided the information is collected in such a manner that it cannot be linked to potential participant identifiers. At each site, procedures and documentation will comply with local IRB/EC requirements.

7.2 Screening Visit

The Screening Visit may take place up to 28 days prior to the Enrollment Visit. Multiple visits may be conducted within this time period to complete all required screening procedures, if necessary. Written informed consent will be obtained before any screening procedures are initiated. For participants who do not meet the eligibility criteria, screening will be discontinued once ineligibility is determined.

Table 4: Screening Visit

Screening Visit		
Component	Procedures	
Administrative and Regulatory	<ul style="list-style-type: none"> ● Obtain written informed consent for screening ● Assign a unique Participant Identification (PTID) Number ● Assess eligibility ● Collect locator information ● Provide reimbursement ● Schedule next visit* 	
Behavioral	<ul style="list-style-type: none"> ● Provide counseling <ul style="list-style-type: none"> – Contraceptive – HIV/STI risk reduction – HIV pre- and post-test 	
Clinical	<ul style="list-style-type: none"> ● Obtain medical and menstrual history ● Obtain concomitant medications ● Prescribe contraceptives* † ● Conduct a physical examination ● Perform a pelvic exam ● Treat or prescribe treatment for UTIs/RTIs/STIs or refer for other findings* 	
Laboratory	Urine	<ul style="list-style-type: none"> ● Collect urine <ul style="list-style-type: none"> – human chorionic gonadotropin (hCG) – Urine culture* † – Nucleic Acid Amplification Test (NAAT) for <i>Neisseria gonorrhoeae</i> and <i>Chlamydia trachomatis</i> (GC/CT)
	Blood	<ul style="list-style-type: none"> ● Collect blood <ul style="list-style-type: none"> – HIV-1 serology – Complete blood count (CBC) with platelets – Chemistries – Syphilis serology
	Pelvic	<ul style="list-style-type: none"> ● Collect pelvic specimens <ul style="list-style-type: none"> – Rapid test for Trichomonas – Herpes lesion testing* † – Vaginal fluid pH* † – Potassium hydroxide (KOH) wet mount for candidiasis* † – Saline wet mount for <i>Bacterial vaginosis</i> (BV)* † – Pap smear interpretation*
Study Product/ Supplies		<ul style="list-style-type: none"> ● Provision of study specified condoms

* if indicated, † per local standard of care

7.3 Enrollment Visit (Day 0)

Please note, if the potential participant is menstruating at this visit, the entire visit should be rescheduled for two days after completion of menses, but must be completed within 4 weeks of the Screening Visit.

In addition, all enrolled participants will receive regular individual HIV counseling, condoms, risk reduction counseling, and treatment for STIs as part of their clinic visits. If, during the course of the study, other new prevention strategies are found to be efficacious and are incorporated into national HIV prevention policies (e.g., tenofovir PrEP), study participants will be counseled about these interventions, and either be offered these interventions by the site or referred to local centers with appropriate expertise, in accordance with WHO/UNAIDS guidelines and local practice and stakeholder consultation.

Table 5: Enrollment Visit

Enrollment Visit		
Component	Procedures	
Administrative and Regulatory	<ul style="list-style-type: none"> • Obtain written informed consent for enrollment • Reassess and confirm eligibility • Review/update locator information • Randomization • Provide reimbursement • Schedule next study visit 	
Behavioral	<ul style="list-style-type: none"> • Conduct behavioral assessment, which will include sexual activity, condom use and intravaginal practices • Provide counseling <ul style="list-style-type: none"> – Contraceptive – HIV/STI risk reduction – HIV pre- and post-test – Protocol adherence, including VR adherence 	
Clinical	<ul style="list-style-type: none"> • Update medical and menstrual history • Update concomitant medications • Provide contraceptives* † • Conduct a physical examination • Perform a pelvic exam • Disclosure of available test results • Treat or prescribe treatment for UTIs/RTIs/STIs or refer for other findings* 	
Laboratory	Urine	<ul style="list-style-type: none"> • Collect urine <ul style="list-style-type: none"> – hCG – Urine culture* † – NAAT GC/CT* †
	Blood	<ul style="list-style-type: none"> • Collect blood <ul style="list-style-type: none"> – Plasma archive – HIV-1 serology

	Pelvic	<ul style="list-style-type: none"> • Collect pelvic specimens <ul style="list-style-type: none"> – Gram stain – Vaginal fluid pH – Endocervical swab – Rapid test for Trichomonas*† – Herpes lesion testing*† – KOH wet mount for candidiasis*† – Saline wet mount for BV*†
Study Product/Supplies		<ul style="list-style-type: none"> • Provide study specified condoms • Provision of VR use instructions; including what to do in cases of ring expulsion or allergic reaction • Provision of one study VR for insertion • Demonstrated attempt to remove and reinsert the ring <ul style="list-style-type: none"> – Digital exam by clinician to check VR placement • Participants may also receive a bottle of water with which to rinse the study ring in the event of a ring expulsion, at select sites with capacity*

* if indicated, † per local standard of care

7.4 Follow-up Visits

7.4.1 Monthly, Quarterly, Semi-Annual Study Visits

The procedures listed below will occur monthly for the duration of follow-up.

Table 6: Follow-up Visits: Monthly, Quarterly, Semi-Annually

Follow-up Visits: Monthly, Quarterly, Semi-Annually	
Component	Procedures
Administrative and Regulatory	<ul style="list-style-type: none"> • Review/update locator information • Provide reimbursement for study visit • Schedule next visit
Behavioral	<ul style="list-style-type: none"> • Adherence assessment • Conduct behavioral assessment, which will include sexual activity, condom use, and intravaginal practices • Acceptability assessment • Conduct social harms assessment • Provide counseling (modified, if necessary) <ul style="list-style-type: none"> – Contraceptive – HIV/STI risk reduction – HIV pre- and post-test – Protocol adherence, including VR adherence
Clinical	<ul style="list-style-type: none"> • Review/update medical and menstrual history • Review/update concomitant medications • Provide contraceptives*† • Perform physical examination* • Perform pelvic examination for the collection pelvic specimens and to assess local safety* • Disclosure of available test results • Record/update AEs • Treat or prescribe treatment for UTIs/RTIs/STIs or refer for other findings*

Laboratory	Urine	<ul style="list-style-type: none"> • Collect urine <ul style="list-style-type: none"> – hCG – NAAT for GC/CT ▶ * † – Urine culture* †
	Blood	<ul style="list-style-type: none"> • Collect blood <ul style="list-style-type: none"> – HIV-1 serology – CBC with platelets ◐ – Chemistries ◐ – Syphilis serology* – Plasma ◐
	Pelvic	<ul style="list-style-type: none"> • Collect pelvic specimens <ul style="list-style-type: none"> – Vaginal fluid – Rapid test for Trichomonas ▶ * † – Vaginal pH ▶ * † – Gram stain ▶ – Endocervical swab ▶ – Herpes lesion testing † – KOH wet mount for candidiasis* † – Saline wet mount for BV* †
Study Product/Supplies		<ul style="list-style-type: none"> • Provision of study specified condoms • Provision of VR use instructions; including what to do in cases of ring expulsion or allergic reaction* • Participant or clinician/designee to remove used study VR • Collection of used study VR • Provision of study VR for insertion <ul style="list-style-type: none"> – Digital exam by clinician to check VR placement ▲* • Bottle of water with which to rinse the study ring in the event of a ring expulsion, at select sites with capacity*

◐ = to be completed at all quarterly visits (Months 3, 6, 9, etc.), ▶ = to be completed at all semi-annual visits only (Months 6, 12, 18, etc.), * if indicated, † per local standard of care, ▲ required at Month 1

7.4.2 Product Use End Visit (PUEV)

Table 7: PUEV

PUEV		
Component	Procedures	
Administrative and Regulatory	<ul style="list-style-type: none"> • Review/update locator information • Provide reimbursement for study visit • Schedule next visit 	
Behavioral	<ul style="list-style-type: none"> • Behavioral assessment, which will include sexual activity, condom use and intravaginal practices • Adherence assessment • Acceptability assessment • Social harms assessment • Provide counseling (modify, if necessary) <ul style="list-style-type: none"> – HIV/STI risk reduction – HIV pre- and post-test 	
Clinical	<ul style="list-style-type: none"> • Review/update medical and menstrual history • Review/update concomitant medications • Provide contraceptives*† • Perform physical examination • Perform pelvic examination • Disclosure of available test results • Record update AEs • Treat or prescribe treatment for UTIs/RTIs/STIs or refer for other findings* 	
Laboratory	Urine	<ul style="list-style-type: none"> • Collect urine <ul style="list-style-type: none"> – hCG – NAAT for GC/CT*† – Urine culture*†
	Blood	<ul style="list-style-type: none"> • Collect blood <ul style="list-style-type: none"> – HIV-1 serology – Syphilis serology – Chemistries – CBC with platelets – Plasma
	Pelvic	<ul style="list-style-type: none"> • Collect pelvic specimens <ul style="list-style-type: none"> – Vaginal fluid – Vaginal pH – Gram stain – Endocervical swab – KOH wet mount for candidiasis*† – Saline wet mount for BV*† – Rapid test for Trichomonas*† – Herpes lesion testing*† – Pap smear interpretation
Study Product	<ul style="list-style-type: none"> • Provision of study specified condoms • Participant or clinician/designee to remove used study VR • Collection of used study VR 	

* if indicated, † per local standard of care.

7.4.3 Study Exit/Termination Visit

The Study Exit/Termination Visit should be scheduled approximately 4 weeks after the PUEV.

Table 8: Study Exit/Termination Visit

Study Exit/ Termination Visit		
Component	Procedures	
Administrative and Regulatory	<ul style="list-style-type: none"> Review/update locator information Provide reimbursement for study visit Schedule next visit* 	
Behavioral	<ul style="list-style-type: none"> Behavioral assessment, which will include sexual activity, condom use and intravaginal practices Provide counseling <ul style="list-style-type: none"> HIV/STI risk reduction HIV pre- and post-test 	
Clinical	<ul style="list-style-type: none"> Review/update medical and menstrual history Review/update concomitant medications Provide contraceptives* † Disclosure of available test results Perform pelvic examination* Record/update AEs Treat or prescribe treatment for UTIs/RTIs/STIs or refer for other findings* 	
Laboratory	Urine	<ul style="list-style-type: none"> Collect urine <ul style="list-style-type: none"> hCG Urine culture* † NAAT for GC/CT* †
	Blood	<ul style="list-style-type: none"> Collect blood <ul style="list-style-type: none"> HIV-1 serology Plasma
	Pelvic	<ul style="list-style-type: none"> Collect pelvic specimens <ul style="list-style-type: none"> Vaginal fluid Vaginal pH* † KOH wet mount for candidiasis* † Saline wet mount for BV* † Rapid test for Trichomonas* † Herpes lesion testing* †
Study Product		<ul style="list-style-type: none"> Provision of study specified condoms

* if indicated, † per local standard of care

7.5 Follow-up Procedures for Participants Who Temporarily Hold or Permanently Discontinue Study Product

7.5.1 Participants Who Become Infected with HIV-1

Participants who become infected with HIV are offered the option to continue follow-up visits per their original study schedule until their originally scheduled study exit date. All participants who become infected with HIV-1 while on study product will be offered enrollment in MTN-015, the MTN Seroconverter Study. Participants are offered

enrollment in MTN-015 (www.mtnstopshiv.org) at the visit when seroconversion confirmation test results are discussed with the participant.

For those who choose to be maintained in ASPIRE follow-up, regardless of co-enrollment in MTN-015, protocol-specified procedures for ASPIRE will continue, except the following:

- HIV serology, HIV pre- and post-test counseling
- Provision of VR, instructions, product adherence counseling
- Complete blood count with platelets
- Chemistries
- Plasma/vaginal fluid sampling
- Scheduled ASPIRE Study Exit/Termination Visit

For participants who delay or decline enrollment in MTN-015, the following procedures are completed as part of the ASPIRE study; these procedures are discontinued immediately if the participant enrolls in MTN-015:

- Plasma
- CD4+ T cell count
- HIV-1 RNA PCR

The aforementioned procedures are done at the following time points:

- The visit (scheduled or interim) at which the participant is given her Western Blot or HIV RNA/DNA test results confirming her HIV-infection
- The 1st, 3rd, 6th, 12th, and 18th scheduled ASPIRE visit after the participant is informed of her HIV-infection.

Please reference the SSP for additional details (www.mtnstopshiv.org).

7.5.2 Participants Who Become Pregnant

All protocol-specified study procedures will continue except the following:

- Provision of VR, product use instructions, and adherence counseling. Product use may be resumed after birth or other termination of the pregnancy, as evidenced by a negative pregnancy test performed by study staff, provided the participant is not breastfeeding. A pelvic exam must be performed prior to resumption to confirm the absence of any findings that would contraindicate resumption, in the opinion of the IoR/designee.
- Pelvic examinations, including vaginal fluid collection, after 24 weeks of pregnancy

A participant who becomes pregnant during the course of study participation may be offered participation in MTN-016, the Prevention Agent Pregnancy Exposure Registry, see Section 7.9 for additional details.

7.5.3 Participants Who Temporarily Hold or Permanently Discontinue Study Product Use

All protocol-specified study procedures will continue except the following:

- Provision of VR, product use instructions, and adherence counseling

Guidance related to permanent discontinuation of study product, including consultation with the PSRT, is included in Section 9.

7.5.4 Interim Visits

Interim visits may be performed at any time during the study, for the following or other reasons:

- For administrative reasons, e.g., a participant may have questions for study staff, or may need to re-schedule a follow-up visit.
- For product-related reasons, e.g., a participant may need an addition VR or want to discuss problems with adherence to product use.
- In response to AEs. When interim contacts or visits are completed in response to participant reports of AEs, study staff will assess the reported event clinically and provide or refer the participant to appropriate medical care (see also Section 9).
- For interim STI counseling and testing in response to STI symptoms.
- For interim HIV counseling and testing in response to presumed exposure to HIV.
- To provide participants with the results of confirmatory HIV test results, per the algorithm in Appendix III.
- For other reasons at participant request.

Interim visits will occur when more than one visit takes place within an allowable visit window. All interim contacts and visits will be documented in participants' study records and on CRFs, if applicable.

7.6 Final Contact

Since participants' Study Exit/Termination Visit include laboratory testing for HIV, a final contact may be required to provide her additional study test results, and post-test counseling, if needed. In addition, for participants who become pregnant during study participation, an additional contact may be required to ascertain the participant's pregnancy outcome. Study sites may complete these contacts at the study site or at community-based locations, depending on site capacities and site and participant preferences. All final contacts will be documented in participant study records.

7.7 Behavioral Evaluations

The following behaviors will be assessed either via Audio Computer-Assisted Self Interviewing (ACASI) or CRFs:

- VR adherence
- VR acceptability
- Sexual activity, including frequency of vaginal and anal sex; condom use; and intravaginal practices

Adherence Assessments

Adherence will be measured at all monthly visits including the final product use visit via questions about duration that the ring is out of the vagina and reasons for expulsion and removal.

Acceptability Assessments

Acceptability will be measured at all scheduled quarterly visits including the final product use visit via questions about discomfort due to the VR, feeling the VR during daily activity and sex, ease of insertion and removal, partner awareness of VR during sex, self and partner attitudes towards the VR.

Sexual activity, condom use and intravaginal practices

These behaviors will be measured at all scheduled quarterly visits, including the final product use visit.

7.8 Clinical Evaluations and Procedures

Physical exams will include the following assessments:

- General appearance
- Weight
- Vital signs
 - Temperature
 - Pulse
 - Blood pressure
 - Respirations
- Abdomen
- Height*
- Lymph nodes*
- Neck*
- Heart*
- Lungs*
- Extremities*
- Skin*
- Neurological*

**may be omitted after the Screening Visit*

Additional clinical assessments may be performed at the discretion of the examining clinician in response to symptoms or illnesses present at the time of the exam.

The required sequence of procedures and specimen collection performed during pelvic exams will be specified in the ASPIRE SSP Manual.

Participants for whom there is documentation of surgical sterilization may have contraceptive counseling omitted, in accordance with any relevant site SOPs.

7.9 Laboratory Evaluations

Local Laboratory

- Urine
 - hCG
 - Urine culture
 - NAAT for *GC/CT*

- Blood
 - Plasma archive (stored at site until notified by MTN Network Laboratory (NL))
 - Plasma (stored at site until notified by MTN NL)
 - Syphilis
 - HIV serology
 - CBC with platelets
 - Chemistries
 - Creatinine, AST, ALT
- Pelvic
 - Rapid test for Trichomonas
 - Vaginal fluid for wet mount microscopy (saline wet mount for BV; KOH for candidiasis)
 - Herpes lesion testing
 - Vaginal fluid pH

Network Laboratory

- Blood
 - HIV-1 confirmatory testing as needed (see Appendix III)
 - Drug concentration in vaginal fluid and blood
- Pelvic
 - Gram stain assessment of vaginal fluid slides
 - Vaginal fluid
 - PK assessments on vaginal fluid
 - Endocervical swab

7.10 Primary HIV-1 Endpoint Determination

All study sites will perform HIV testing per the algorithm in Appendix III for purposes of primary endpoint determination. Prior to study initiation, all sites will have validated this algorithm in accordance with the policies described in the MTN Manual of Operations (www.mtnstopshiv.org). All sites will participate in ongoing proficiency testing of their HIV testing procedures throughout the course of the study. The HIV test kits used at each site are pre-approved by the MTN NL; at each testing time point when rapid tests are used at least one FDA-approved rapid test kit is used. All Western blot testing is performed using FDA-approved test kits.

The MTN NL will verify HIV testing performed at the study site laboratories for purposes of eligibility determination and primary outcome ascertainment as follows:

- The NL will test Study Entry, PUEV, and scheduled Study Exit/Termination Visit specimens from a 10% random sample of participants enrolled at each site for evidence of HIV infection using FDA-licensed tests. Study Entry specimens are collected at participants' Enrollment Visit(s). If any false-negative local laboratory

results are identified, the NL will test the respective Study Entry, PUEV and scheduled Study Exit/Termination Visit specimens from all enrolled participants from that Clinical Research Site.

- The NL will test the Study Entry and Seroconversion specimens from all study participants identified by the local laboratories as having become infected with HIV during the study follow-up period. The NL will also test matched Study Entry and Follow-Up specimens from a random sample of uninfected participants (equal to the number of seroconversions). Study Entry specimens are collected at participants' Enrollment Visit. Seroconversion specimens are collected at the schedule specified in Section 7.5.1. All specimens will be tested for evidence of HIV infection using FDA-licensed tests. For seroconverters, Study Entry specimens also will be tested by RNA PCR.

NL staff will follow-up directly with site staff to resolve any quality control or quality assurance problems identified through proficiency testing, on-site assessments, and/or confirmatory HIV testing.

In addition to all of the above, an endpoint adjudication committee will provide guidance on endpoint determination to the Protocol Team on an as needed basis. See the MTN Manual of Operational Procedures (MOP) for detailed information on the composition, roles, and responsibilities of the endpoint adjudication committee (www.mtnstopshiv.org).

7.11 Specimen Collection and Processing

Each study site will adhere to the standards of Good Clinical Laboratory Practice (<http://apps.who.int/tdr/publications/tdr-research-publications/gclp-web/pdf/gclp-web.pdf>), the MTN Network Laboratory Manual (www.mtnstopshiv.org), in accordance with current DAIDS Laboratory Requirements, ASPIRE Study Specific Procedures Manual (www.mtnstopshiv.org), and site standard operating procedures for proper collection, processing, labeling, transport, and storage of specimens at the local laboratory. Specimen collection, testing, and storage at the site laboratories will be documented when applicable using the Laboratory Data Management System (LDMS). In cases where laboratory results are not available due to administrative or laboratory error, sites are permitted to re-draw specimens.

7.12 Specimen Handling

Specimens will be handled in accordance with current requirements for DAIDS Sponsored and/or Funded Laboratories in Clinical Trials. (<http://www.niaid.nih.gov/labsandresources/resources/daidsclinrsrch/documents/labpolicy.pdf>)

7.13 Biohazard Containment

As the transmission of HIV and other blood-borne pathogens can occur through contact with contaminated needles, blood, and blood products, appropriate blood and secretion precautions will be employed by all personnel in the drawing of blood and shipping and handling of all specimens for this study as recommended by the U.S. Centers for Disease Control and Prevention (CDC) and National Institutes of Health (NIH). All biological specimens will be transported using packaging mandated by US Code of Federal Regulations (CFR) 42 Part 72. All dangerous goods materials, including diagnostic specimens and infectious substances, must be transported according to instructions detailed in the International Air Transport Association (IATA) Dangerous Goods Regulations. Biohazardous waste will be contained according to institutional, transportation/carrier, and all other applicable regulations.

8 ASSESSMENT OF SAFETY

8.1 Safety Monitoring

Site IoRs/designees are responsible for continuous close safety monitoring of all study participants, and for alerting the Protocol Team if unexpected concerns arise. A subgroup of the Protocol Team, including the Protocol Co-Chairs, DAIDS Medical Officer, Protocol Safety Physician(s), and SCHARP Clinical Affairs Safety Associate will serve as the PSRT. The MTN SDMC prepares routine AE and clinical data reports (blinded to treatment assignment) for review by the PSRT, which meets via conference call approximately once per month or as needed throughout the period of study implementation to review safety data, discuss product use management, and address any potential safety concerns.

The National Institute of Allergy and Infectious Diseases (NIAID) Prevention Trials Data and Safety Monitoring Board (DSMB) monitors participant safety throughout the study. The DSMB meets routinely, see Section 10.7.2 for additional details. At the time of these reviews, or at any other time, the DSMB may recommend that the study proceed as designed, proceed with design modifications, or be discontinued.

8.2 Adverse Events Definitions and Reporting Requirements

8.2.1 Adverse Events

An AE is defined as any untoward medical occurrence in a clinical research participant administered an investigational product and which does not necessarily have a causal relationship with the investigational product. As such, an AE can be an unfavorable or unintended sign (including an abnormal laboratory finding, for example), symptom or disease temporally associated with the use of an investigational product, whether or not considered related to the product. This definition is applied to all study groups, and is

applied to both groups beginning at the time of enrollment (i.e., once a participant is randomized). The term “investigational product” for this study refers to both study products.

Study participants will be provided instructions for contacting the study site to report any untoward medical occurrences they may experience. In cases of potentially life-threatening events, participants will be instructed to seek immediate emergency care. Where feasible and medically appropriate, participants will be encouraged to seek evaluation where a study clinician is based, and to request that the clinician be contacted upon their arrival. With appropriate permission of the participant, whenever possible, records from all non-study medical providers related to untoward medical occurrences will be obtained and required data elements will be recorded on study CRFs. All participants reporting an untoward medical occurrence will be followed clinically until the occurrence resolves (returns to baseline) or stabilizes.

Study site staff will document in source documents all AEs reported by or observed in enrolled study participants regardless of severity and presumed relationship to study product.

Study staff also will report on CRFs the following subset of AEs reported by or observed in enrolled participants:

- All genital, genitourinary, and reproductive system AEs
 - Fetal losses (e.g., spontaneous abortions, spontaneous fetal deaths, stillbirths) will not be reported as AEs. However, untoward maternal conditions that either result in or result from fetal losses are reported as reproductive system AEs
 - Genital bleeding clinically assessed to be expected is not an AE
- All AEs of severity Grade 2 or higher
- All serious AEs
- All AEs that result in permanent discontinuation of study product use
- All lab test abnormalities specified in the DAIDS Table for Grading Adult and Pediatric Adverse Events, Version 1.0, December 2004 (Clarification dated August 2009), that are not otherwise associated with a reported clinical AE
- AEs that do not meet the above-listed criteria but do meet expedited reporting requirements per Section 8.3 below; this includes all congenital anomalies identified in the fetuses and/or infants of study participants

AE severity and laboratory tests will be graded per the DAIDS Table for Grading Adult and Pediatric Adverse Events, Version 1.0, December 2004 (Clarification dated August 2009) and the Female Genital Grading Table for Use in Microbicide Studies (Addendum 1 to the DAIDS Table for Grading Adult and Pediatric Adverse Events, Version 1.0, December 2004 (Clarification dated August 2009), except that asymptomatic BV and asymptomatic candidiasis will not be reportable AEs. In cases where a genital AE is covered in both tables, the Female Genital Grading Table for Use in Microbicide Studies will be the grading scale utilized.

All AE Log forms completed for each participant should be reviewed at the study exit visit and updated as needed. For AEs that are ongoing at the exit visit, the status/outcome of the AE should be updated to “continuing at end of study participation” and the AE Log form should be re-faxed to SCHARP DataFax. For any serious or expedited AEs (SAEs/EAEs) that are continuing at a participant’s study exit visit, the IoR/designee must establish a clinically appropriate follow-up plan for the AE. At a minimum, the SAE/EAE must be re-assessed by study staff 30 days after the participant’s study exit visit; additional evaluations also may take place at the discretion of the IoR/designee. The same approach must be taken for any AEs that are found to have increased in severity at the study exit visit. For those AEs requiring re-assessment, if the AE has not resolved or stabilized at the time of re-assessment, study staff will continue to re-assess the participant at least once per month while the study is ongoing. After the study has ended, all AEs requiring re-assessment will be re-assessed at least once within the 30-60 days after the study end date. The PSRT may advise study staff as to whether any additional follow-up may be indicated on a case by case basis. For AEs that are re-assessed after study exit, information on the status of the AE at the time of re-assessment will be recorded in source documents only — no updates should be made to AE Log CRFs based on the re-assessments.

8.2.2 Serious Adverse Events

SAEs will be defined by the Manual for Expedited Reporting of Adverse Events to DAIDS (Version 2.0, January 2010), as AEs occurring at any dose that:

- Results in death
- Is life-threatening
- Requires inpatient hospitalization or prolongation of existing hospitalization
- Results in persistent or significant disability/incapacity
- Is a congenital anomaly/birth defect
- Is an important medical event that may not result in death, be immediately life-threatening, or require hospitalization but may jeopardize the participant or require intervention to prevent one of the outcomes listed in the definition above.

8.2.3 Adverse Event Relationship to Study Product

Relatedness is an assessment made by a study clinician of whether or not the event is related to the study agent. Degrees of relatedness will be categorized according to current DAIDS-approved guidelines. Per the Manual for Expedited Reporting of Adverse Events to DAIDS (Version 2.0, January 2010), the relationship categories that will be used for this study are:

- *Related:* There is a reasonable possibility that the AE may be related to the study agent(s)
- *Not Related:* There is not a reasonable possibility that the AE is related to the study agent(s)

8.3 Expedited Adverse Event Reporting Requirements

8.3.1 Adverse Event Reporting to DAIDS

Requirements, definitions and methods for expedited reporting of AEs are outlined in Version 2.0 of the DAIDS EAE Manual, which is available on the RSC website at <http://rsc.tech-res.com/safetyandpharmacovigilance/>. For each study participant, expedited AE reporting will be undertaken throughout the scheduled duration of follow-up, i.e., from the time of random assignment through study termination.

The DAIDS Adverse Experience Reporting System (DAERS), an internet-based reporting system, must be used for expedited AE reporting to DAIDS. In the event of system outages or technical difficulties, expedited AEs may be submitted via the DAIDS EAE Form. For questions about DAERS, please contact DAIDS-ES at DAIDS-ESSupport@niaid.nih.gov. Site queries may also be sent from within the DAERS application itself.

Where DAERS has not been implemented, sites will submit expedited AEs by documenting the information on the current DAIDS EAE Form. This form is available on the RSC website, <http://rsc.tech-res.com/safetyandpharmacovigilance/>. For questions about EAE reporting, please contact the RSC (DAIDSRSCSafetyOffice@tech-res.com).

8.3.2 Reporting Requirements for this Study

- The SAE Reporting Category, as defined in Version 2.0 of the DAIDS EAE Manual, will be used for this study
- The study agents for which expedited reporting are required are the dapivirine VR and the placebo VR
- For all SAEs submitted, sites must file an initial report and an update to IPM and the DAIDS Medical Officer with the final or stable outcome unless the initial SAE submitted had a final or stable outcome noted already

8.3.3 Grading Severity of Events

The grading of severity of events and the reporting period will be the same as for all AEs, as described in Section 8.2.1. The most current Division of AIDS Table for Grading Adult and Pediatric Adverse Events, Version 1.0, December 2004 (Clarification, August 2009) and the Female Genital Grading Table for Use in Microbicide Studies (Addendum 1 to the DAIDS Table for Grading Adult and Pediatric Adverse Events, Version 1.0, December 2004 (Clarification, August 2009)), will be used and is available on the RSC website at <http://rsc.tech-res.com/safetyandpharmacovigilance/>.

8.3.4 Expedited AE Reporting Period

- The expedited AE reporting period for this study begins once the participant is randomized and continues up through the participant's final study visit (Study Exit/Termination Visit).
- After the protocol-defined AE reporting period, unless otherwise noted, only suspected, unexpected serious adverse reactions (SUSARs) as defined in Version 2.0 of the EAE Manual will be reported to DAIDS if the study staff become aware of the events on a passive basis (from publicly available information).

8.4 Social Harms Reporting

Although study sites will make every effort to protect participant privacy and confidentiality, it is possible that participants' involvement in the study could become known to others and that social harms may result. For example, participants could be treated unfairly, or could have problems being accepted by their families, partners and/or communities. Social harms that are judged by the IoR/designee to be serious or unexpected will be reported to the PSRT and responsible site ECs/IRBs according to their individual requirements. In the event that a participant reports social harm, every effort is made by study staff to provide appropriate care and counseling to the participant, and/or referral to appropriate resources for the safety of the participant as needed. Each site will provide such care and counseling in accordance with standardized guidance provided in the ASPIRE SSP Manual. While maintaining participant confidentiality, study sites may engage their community advisory boards (CABs) in exploring the social context surrounding instances of social harm.

8.5 Regulatory Requirements

Information on all reported CRFs will be included in reports to the FDA and other applicable government and regulatory authorities. Site IoRs/designees will submit AE information in accordance with local regulatory agencies' or other local authorities' requirements. Site IoRs/designees also will submit AE information and any other relevant safety information to their ECs/IRBs in accordance with ECs/IRB requirements.

9 CLINICAL MANAGEMENT

Guidelines for clinical management and temporary product hold/permanent discontinuation of study product are outlined in this section. In general, the IoR/designee has the discretion to hold study product temporarily at any time if s/he feels that continued product use would be harmful to the participant or interfere with treatment deemed clinically necessary. Unless otherwise specified below, the IoR/designee should immediately consult the PSRT for further guidance on resuming study product, continuing the hold temporarily, or progressing to permanent discontinuation of study product. The IoR/designee will document all temporary product holds and permanent discontinuations on applicable CRFs.

9.1 Grading System

AE severity grading is described in Section 8.3.3.

9.2 Dose Modification Instructions

No dose modifications will be undertaken in this study.

9.3 General Criteria for Temporary Hold and Permanent Discontinuation of Study Product

A participant will be permanently discontinued from VR product use by the IoR/designee for any of the following reasons:

- Acquisition of HIV-1 infection; such participants will not resume product use at any time. The study VR should be held beginning immediately upon recognition of the first reactive rapid HIV test. If via the algorithm in Appendix III the participant is determined to be HIV-uninfected, she may resume product use. The IoR/designee must permanently discontinue the study VR if HIV-1 infection is confirmed.
- Allergic reaction to the VR.

A participant will be temporarily held from study VR for any of the following reasons:

- A reactive rapid HIV test.
- Pregnancy. A participant who becomes pregnant may resume product use after giving birth or other termination of the pregnancy, as evidenced by a negative pregnancy test performed by study staff, provided the participant is not breastfeeding. A pelvic exam must be performed prior to resumption to confirm the absence of any findings that would contraindicate resumption, in the opinion of the IoR/designee.
- Breastfeeding. Product use may resume when the participant reports complete cessation of breastfeeding.

- Report of use of PEP for HIV exposure. The participant may resume product use when she reports completion of PEP and is confirmed HIV-uninfected based on testing performed at the study site per the algorithm in Appendix III.
- Participant is unable or unwilling to comply with required study procedures, or otherwise might be put at undue risk to their safety and well-being by continuing product use, according to the judgment of the IoR/designee. The IoR/designee must consult the PSRT on all temporary product holds instituted for this reason for further guidance on resuming product use, continuing the temporary hold, or progressing to permanent discontinuation. If product use is temporarily held/permanently discontinued for this reason, but the underlying reason for the temporary hold later resolves, the IoR/designee should consult the PSRT to resume product use at that time.

9.4 Temporary Product Hold/Permanent Discontinuation in Response to Observed Adverse Events

Grade 1 or 2

In general, a participant who develops a Grade 1 or 2 AE not specifically addressed below, regardless of relatedness to study product, may continue product use.

Grade 3

Participants who develop a Grade 3 AE that is not specifically addressed below and is judged by the IoR/designee to be not related to study product may continue product use.

In general, for participants who develop a Grade 3 AE not specifically addressed below, judged by the IoR/designee to be related to study product, and unless otherwise decided in consultation with the PSRT, the IoR/designee should:

- Temporarily hold the study product.
- Re-evaluate the participant at least weekly for up to 2 weeks.
- Resume study product if improvement to \leq Grade 2 is documented within 2 weeks.
- Consult PSRT regarding further product management if improvement to severity \leq Grade 2 cannot be documented within 2 weeks.

If product use is resumed and the same Grade 3 AE deemed related to study product, recurs at any time, the IoR/designee must temporarily hold study product and consult the PSRT for further guidance on continuing the temporary hold or progressing to permanent discontinuation of the study product.

Grade 4

Participants who develop a Grade 4 AE (regardless of relationship to study product), that is not specifically addressed in below, should have the study product held. The IoR/designee must consult the PSRT and continue the temporary product hold until a recommendation is obtained from the PSRT.

9.5 Genital Sexually Transmitted Infection, Reproductive Tract Infection and Other Clinical Findings

The IoR/designee should manage STI/RTI per local guidelines or current WHO guidelines, available at <http://www.who.int/en/>. Observed single dose treatment should be provided whenever possible. Vaginally applied medications should not be used, except that vaginal azoles should be used to treat symptomatic candidiasis among pregnant women.

A thorough evaluation of genital complaints is expected in the context of this study; however, syndromic management of genital symptoms is acceptable while awaiting laboratory results if such practice is in line with the local standards of care. Observed single dose treatment should be provided whenever possible, per clinician discretion. When clinically appropriate, investigators should use oral or parenteral (in the case of syphilis, for example) medications when at all possible to avoid intravaginal medication use.

- Study VR need not be held in the event of an STI/RTI requiring treatment, unless other temporary product hold/permanent discontinuation guidelines apply.
- Should the IoR/designee determine that a temporary hold is warranted, consultation with the PSRT is required.

If a suspected finding is reported by participant between scheduled visits, an interim visit may be scheduled at the discretion of the site investigator. Management of genital events observed at scheduled or interim visits will be in accordance with the following:

Superficial epithelial disruption (abrasion/peeling)

- Continue study VR use
- Perform naked eye evaluation
- Re-evaluate by speculum examination in 3-5 days
- If condition worsens, temporarily hold study VR use and consult the PSRT; otherwise continue study VR use

Deep epithelial disruption (ulceration)

- Remove study VR for deep epithelial disruption confirmed by site investigator
- Re-evaluate in 3-5 days and reinstate study VR use if resolved
- If unresolved at 3-5 days, re-evaluate within 2-3 days. If resolved at that time, may reinstate study VR use. If unresolved at this second reevaluation, continue temporary product hold, consult with PSRT regarding permanent discontinuation, and provide care per local standard
- If there is reoccurrence with no identified etiology, continue temporary product hold and consult the PSRT regarding permanent discontinuation

Localized erythema or edema: area of less than 50% of vulvar surface or combined vaginal and cervical surface

- Continue study VR use
- Perform naked eye evaluation
- If asymptomatic, re-evaluate at next regularly scheduled visit
- If symptomatic, re-evaluate by speculum examination in 3-5 days
- If worsened significantly, temporarily hold study VR use and consult the PSRT; otherwise continue study VR use

Generalized erythema or severe edema: area of more than 50% of vulvar surface or combined vaginal and cervical surface affected by erythema

- Remove study VR
- Perform naked eye evaluation
- Re-evaluate in 3-5 days and reinstate study VR use if resolved
- If unresolved at 3-5 days, re-evaluate within 2-3 days. If resolved at that time may reinstate use. If unresolved at this second reevaluation, continue temporary product hold, consult with PSRT regarding permanent discontinuation, and provide care per local standard

Unexpected genital bleeding

- Continue study VR use (at study clinician's discretion)
- Perform naked eye evaluation
- If determined to be due to deep epithelial disruption, refer to guidelines above; otherwise continue study VR use

Cervicitis (including findings on exam such as inflammation and/or friability)

- Remove study VR
- Evaluate for GC/CT; consider syndromic management, pending results of testing and per clinician discretion
- If GC/CT detected, provide or prescribe treatment and consult PSRT
- If GC/CT is not detected, reevaluate in 3 days. If all symptoms and signs are resolved at that time continue study VR use

Genital petechia(e)

- Continue study VR use
- Perform naked eye evaluation
- No further evaluation or treatment is required

Genital ecchymosis

- Continue study VR use
- Perform naked eye evaluation
- No further evaluation or treatment is required

The study product need not be held in the event of an STI/RTI requiring treatment, unless other temporary product hold/permanent discontinuation guidelines apply. Should the IoR/designee determine that a temporary product hold is warranted, notification of the PSRT is required.

9.6 HIV-1 Infection

A participant who has a positive test for HIV-1 must have study product held, but will not be withdrawn from the study. If the participant is subsequently determined to be HIV-uninfected according to the algorithm in Appendix III, study product may be resumed. If HIV-1 infection is confirmed, study product will be permanently discontinued by the IoR/designee. Participants identified as infected with HIV are managed or referred for management according to the local standard of care. These participants are also offered participation in MTN-015, the MTN Seroconverter Study, which also includes provisions for the clinical management and/or referral of participants infected with HIV.

The level of care provided at the referral sites is at a level that meets or exceeds the community standard for HIV-1 care. Written SOPs for referral for HIV-1 care and treatment are in place at each study site. Study site investigators have identified facilities offering psychological and social services and medical care, including antiretroviral therapy (ART), to people infected with HIV-1 in the study countries. Some of the research sites are part of health care institutions that provide HIV-1 care and support, and can refer women to those services. Other sites have established referral agreements with programs to expand access to ART.

At every study visit, study staff will actively follow-up on prior referrals to HIV-1 care and support services, to determine whether the participant sought the care to which she was referred, the outcome of the referral, and whether additional referrals are needed. All follow-up actions, outcomes, counseling, and plans for next steps are documented in participant study records. Results of study laboratory testing may be helpful in clinical management; these results are provided to the participant and her medical provider as soon as they are available.

9.7 Pregnancy

A participant who becomes pregnant at any time during the study must have study product temporarily held, but will not be withdrawn from the study. Every effort will be made to have the study participant continue in modified follow-up until her study termination visit or pregnancy outcome is ascertained. The IoR/designee will counsel any participant who becomes pregnant regarding possible risks to the fetus according to site SOPs. The IoR/designee also will refer the participant to all applicable services; however, sites will not be responsible for paying for pregnancy-related care.

Participants who become both pregnant and HIV-infected will have expedited HIV-1 resistance testing performed at the MTN NL to provide information about possible resistance that might impact the efficacy of ART regimens to reduce mother-to-child

HIV-1 transmission. The participant will be referred to local providers for antenatal care, and prevention of mother-to-child transmission services. HIV testing for infants is provided by the study if not otherwise accessible by the participant.

A participant who becomes pregnant during the course of study participation may be offered participation in MTN-016, the Prevention Agent Pregnancy Exposure Registry. This registry is anticipated to capture pregnancy outcomes as well as infant health information, (including growth and development), to evaluate the safety and teratogenic risks of microbicide and oral PrEP exposure in pregnancy.

All pregnancies will be followed until a pregnancy outcome can be ascertained (or, in consultation with the PSRT, it is determined that the pregnancy outcome cannot be ascertained). This includes participants who are pregnant at the Study Exit/Termination Visit. Pregnancy outcomes are reported on relevant CRFs.

9.8 Criteria for Early Termination of Study Participation

Participants may voluntarily withdraw from the study for any reason at any time. The IoR also may withdraw participants from the study to protect their safety and/or if they are unwilling or unable to comply with required study procedures, after consultation with the PSRT. Participants also may be withdrawn if the study sponsors, government or regulatory authorities, including the FDA and Office for Human Research Protections (OHRP), or site IRBs/ECs terminate the study prior to its planned end date. Every reasonable effort is made to complete a final evaluation of participants who withdraw or are withdrawn from the study prior to completing follow-up. Study staff members will record the reason(s) for all withdrawals in participants' study records. In the event that participants who voluntarily withdraw from the study wish to re-join the study, they may resume product use (if applicable) and follow-up through their originally scheduled study exit date, pending consultation with the PSRT.

10 STATISTICAL CONSIDERATIONS

10.1 Overview and Summary of Design

This is a Phase 3, multi-site, randomized, double-blinded placebo-controlled trial. A total of approximately 3476 participants will be randomly assigned in a 1:1 ratio to either dapivirine VR or placebo VR.

It is estimated that 120 endpoints will be reached approximately 24 months from the start of randomization, allowing for a loss to follow-up rate of 1%/month. Based on the expected HIV-1 baseline incidence rates at the sites, the accrual and follow-up plan should achieve the target of 120 HIV-1 seroconversions needed for appropriate statistical power for the study primary objectives.

10.2 Study Endpoints

10.2.1 Primary Endpoints

- **Effectiveness**

- HIV-1 infection as measured by seroconversion at the end of the investigational product use period with seroconversion defined by the algorithm in Appendix III

- **Safety**

- Grade 2 AEs judged to be related to study product
- Grade 3 and 4 AEs
- All serious adverse events

10.2.2 Secondary Endpoints

- **Acceptability**

Consistent with the secondary objective to evaluate the acceptability of the study VR (dapivirine or placebo) in HIV-uninfected women, when inserted once every 4 weeks over the investigational product use period, the following secondary endpoint will be assessed:

- Participant report of participant and partner-related acceptability including (dis)comfort, ring insertion and removal/ expulsion issues, change in sexual feelings, willingness to use in the future

- **Adherence**

Consistent with the secondary objective to evaluate the adherence to the study VR (dapivirine or placebo) in HIV-uninfected women, when inserted once every 4 weeks over the investigational product use period, the following secondary endpoint will be assessed:

- Frequency of study VR removal/expulsions (voluntary and involuntary) and duration without VR inserted in vagina

- **HIV-1 Drug Resistance**

Consistent with the secondary objective to assess the occurrence of HIV-1 drug resistance in women who acquire HIV-1 infection while using study product, the following secondary endpoint will be assessed:

- HIV-1 drug resistance mutations among participants who acquire HIV-1 infection

- **Drug Concentration Data**

Consistent with the secondary objective to evaluate the relationship between drug concentration and HIV-1 seroconversion, the following secondary endpoint will be assessed:

- Steady-state drug concentrations in blood and vaginal fluid

10.3 Sample Size and Power Calculations

10.3.1 Primary Endpoint

To achieve an overall effect of preventing HIV-1 infection at the population level, a minimum bound greater than 0% for the effectiveness in individual efficacy trials needs to be achieved to offset any negative indirect effects potentially induced by an increase in risky behavior (e.g., sexual disinhibition) and/or in changes in condom usage. Indeed, mathematical modeling has shown that for an HIV vaccine to be effective at the population level, the minimum (direct) efficacy may need to be 30% or greater.^{16,27} Recently, similar mathematical models suggest that the (direct) efficacy of oral PrEP should be above 25-50%. Similarly, the (direct) efficacy of vaginal microbicides may also need to be above 25-50% to offset potential changes in condom usage.^{28,29}

Based on this, several of the ongoing or planned oral PrEP trials are powered to rule out a lower effectiveness between 10% and 30%. The protocol team has set the minimum lower bound for the effectiveness of the study product at 25%. Therefore the null hypothesis is that the active product will be no more than 25% effective. That is, the trial is powered to detect effectiveness of at least 60% and to rule out effectiveness of 25% or lower.

The sample size calculation follows directly from Fleming and Harrington, 1991, pages 394-395 with a variance inflation adjustment for null and alternative relative risks outside the range 0.5-2.0.³⁰ Here, the null relative risk is 0.75, while the alternative is 0.40. The formula for calculating the required number of events is:

$$L = \frac{Z_{0.9} - Z_{0.025}}{(\ln R_0 - \ln R_1) (2 \sqrt{VIF})}^2,$$

where $VIF = \frac{1+R_0^2}{8R_0} + \frac{1+R_1^2}{8R_1}$, R_0 is the relative risk under the null hypothesis and R_1 is the relative risk under the alternative hypothesis.

With $R_0 = 0.75$ and $R_1 = 0.40$, the formula above indicates that a trial with 120 events would provide 90% power to detect a minimum 60% reduction in risk of HIV-1 infection

while ruling out a 25% or smaller reduction using a log-rank test having a one-sided positive error rate of 0.025.

In HTPN 035,³¹ HIV incidence rates in the 0.5% PRO2000 Gel, BufferGel, Placebo Gel and No Gel arms were 2.7, 4.1, 3.9 and 4.0 per 100 women-years, respectively. In this study design, we choose 3.9% to be consistent with the lower estimate of the two placebo arms in HPTN 035. We expect this may be a conservative estimate of incidence. Studies in similar settings saw higher incidence rates including FEM-PrEP (5%/year) and CAPRISA 004 (9.1%/year). Assuming an annual infection rate of 3.9% in the placebo arm, the trial must include 4396 person-years of follow-up.

10.4 Participant Accrual, Follow-up and Retention

Assuming participants are accrued according to the figure below for a total of 3476 participants and an annual overall infection rate of 2.73%, it would take approximately 24 months from the start of randomization to reach the required 120 endpoints. This calculation allows for a loss to follow-up rate of 1% per month.

Month of study	1	2	3	4	5	6	7	8	9	10	11	12
Number enrolled	25	75	150	200	275	350	400	400	400	400	400	400

Figure 1: Projected Enrollment Used for Study Design

Periodically during the 12-month accrual period, the MTN SMC, DSMB, and/or the Protocol Team will review performance data from each study site — including accrual rates, retention rates, protocol adherence measures, data quality measures, and HIV-1 incidence rates — to determine whether enrollment slots should be shifted across sites to achieve the study objectives more efficiently and to determine when to discontinue accrual. The Protocol Team will make every effort to discontinue accrual approximately 12 months prior to when the targeted number of incident HIV-1 infections (i.e., n=120) will be observed.

It is expected that follow-up will be completed at 24 months from the start of randomization, not including the approximate 4 week period between the scheduled PUEV and Study Exit/Termination Visit.

Note that 99% retention per month (~89% per year) is used to be conservative for the sample size calculations; however retention of 95% per year will be the target.

The assumed HIV-1 seroincidence rates are averages of best available estimates based on ongoing or recently completed research studies and/or other available epidemiologic information from populations as similar as possible to the study population. In particular, estimates from populations receiving condom counseling were used when available.

10.5 Randomization

Participants will be randomized in a 1:1 ratio to the two arms of the study. Study arm randomization will be stratified by site to ensure balanced assignment for products at each site. The randomization scheme will be generated and maintained by the MTN SDMC. Assignment of randomization is considered the effective act of participant enrollment.

10.6 Blinding

Both study staff and participants will be blinded to the random assignments of participants to the study treatment arms. Within the active and placebo arm, study products are supplied in identical packaging. Randomization documentation and other pharmacy records will be stored in a secure location in the site pharmacy (apart from the rest of the participant file). This information must not be accessible to study staff members who complete other study procedures with participants. Blinding will be maintained until all data are entered into the study database, all study endpoint data and other data included in the final analysis have been cleaned and verified, and the data are ready for final analysis. This will be explained to participants as part of the informed consent process. There are no circumstances under which it is expected that unblinding will be necessary for provision of medical treatment or to otherwise protect the safety of study participants. As described in Section 9, in the event that an IoR/designee is concerned that a participant might be put at undue risk by continuing product use, the IoR/designee may discontinue product use by this participant, however knowledge of the specific product to which the participant was assigned should not be necessary to guide further follow-up and/or treatment. If an IoR/designee feels that specific product knowledge is necessary to protect participant safety, the IoR/designee will notify the PSRT to consider and rule upon the request. In the event of a serious adverse event requiring submission as an expedited Individual Case Safety Report to regulatory authorities, unblinding information for the specific participant will be provided to DAIDS by SCHARP. The DSMB will be provided with unblinded product coding information with closed study reports upon request.

10.7 Data and Safety Monitoring Procedures

10.7.1 Study Monitoring Committee

In addition to the safety monitoring done by the PSRT, the MTN SDMC will prepare study progress reports for review by the MTN SMC. The SMC will conduct interim reviews of study progress (pooled over study arms), including rates of participant accrual, retention, rates of adherence to study product, and HIV-1 rates. These reviews will take place approximately every 6 months, or as needed. Typically, as much as possible, a SMC review is planned 2 – 4 weeks prior to a DSMB review such that recommendations from the SMC may be passed along to the DSMB. This process allows the DSMB to focus less on trial operational issues and more on safety. However,

all data presented to the SMC will also be presented to the DSMB. At the time of these reviews, or at any other time, the SMC may recommend that the study proceed as designed, proceed with design modifications, or be discontinued.

Based on the assumptions of Section 10.3, the target HIV-1 seroconversion rate is 2.73% for the entire trial. If the observed HIV-1 rate is substantially lower or higher than expected, the protocol team may need to develop plans for adjusting the accrual and/or the length of follow-up (see Section 10.4). Based on prior performance the sites have adequate additional capacity to effectively respond to seroincidence rates much lower than those initially used for the power calculations.

Note that the monitoring of the trial target HIV-1 rate as described above was successfully implemented in HPTN 035. Further monitoring of the HIV-1 rates will be performed by the DSMB, which will ensure that the target number of primary endpoints will be achieved.

10.7.2 Data and Safety Monitoring Board (DSMB)

DSMB reviews of study safety data will be conducted approximately every six to twelve months. A no-data DSMB meeting will be scheduled prior or close to study initiation where the protocol and the complete interim monitoring plan will be presented to the DSMB members. At subsequent DSMB reviews, besides safety and efficacy data presentations, tables will be prepared for these reviews to assess the study conduct operational characteristics (e.g., accrual, adherence, retention, HIV-1 incidence). That information will be compared to the protocol assumptions, and alterations will be made to the study design (e.g., increase or decrease in accrual and/or follow-up and/or number of sites) if recommended by the DSMB.

10.7.3 Monitoring Quality of Study Conduct Operational Characteristics and Implementation

The study may be terminated or modified for poor accrual/recruitment, adherence/product use, retention, and/or low HIV-1 acquisition rate. Regular reports will be provided to the DSMB and SMC that outline the potential impact on the study's ability to detect a difference between the treatment arms if there are deviations from the statistical design in terms of accrual/recruitment, adherence/product use, retention, and/or low HIV-1 acquisition rate.

10.7.4 Monitoring of Safety and Efficacy Endpoints

The DSMB may recommend early termination of the study or modification when there is clear evidence of benefit, futility, or harm, or may recommend continuation of the study if the balance between potential benefit and harm remains adequate. Therefore, the DSMB may recommend stopping or modifying the study early in the following situations:

- Clear evidence of serious safety problems including:
 - An excess in frequency of any AEs (judged by the DSMB to be harmful to the participants) in the active product arm.
 - An excess in frequency of any SAEs (Grade 4 and higher) in the active product arm.
 - An excess in frequency of the primary safety endpoints as defined in Section 10.2.1 in the active product arm.
- Clear evidence of benefit/harm:
 - A statistically significant difference in the rate of HIV-1 infection between the active product arm and the placebo arm (appropriately adjusted for sequential monitoring of the trial)

Efficacy will be monitored with a Type 1 error rate of 2.5% against a null hypothesis of 25% effectiveness.

Harm will be monitored with a Type 1 error rate of 2.5% against a null hypothesis of 0% effectiveness.

- Clear evidence of futility:
 - Futility is defined to be results sufficient to rule out that the rate of HIV-1 infection in the active product arm is smaller than the rate of HIV-1 infection in the placebo arm leading to a lack of difference in the rate of HIV-1 infection between the two arms appropriately adjusted for the sequential monitoring of the trial.

Note that the futility stopping rules will be based on a null hypothesis of no reduction (i.e., 0% effectiveness) with a false positive error rate of 2.5%. The rationale for this is the current lack of proof for VR effectiveness for women at risk of sexual acquisition of HIV-1. While the protocol team does strongly believe effectiveness of these interventions would need to rule out less than 25% effectiveness to be a viable public health intervention, demonstrated effectiveness > 0% that does not rule out 25% would still offer hope of a potentially effective prevention methodology, albeit needing further evaluation. Therefore, the protocol team would propose to the DSMB only stopping for futility if an intervention shows no evidence of reduction in HIV-1 infection rates.

Interim and final analyses will be adjusted to maintain an overall type I error rate. Adjustments will be based on Lan and DeMet's implementation of the O'Brien-Fleming grouped sequential stopping boundary with the time scale measured on the cumulative number of primary endpoints.³² This implementation will permit early stopping only for very strong positive or negative effects and maintains nearly all of the nominal power for the final analysis.

The DSMB may request additional analyses of the safety, toxicity, and/or effectiveness data from this study. The Statistical Analysis Plan for this study will provide further details on the interim monitoring strategy including the specifics of the above guidelines for operational, efficacy, harm and futility and other relevant details.

10.8 Primary Analysis

When the use of descriptive statistics to assess group or site characteristics or differences is required, the following methods will be used: for categorical variables, the number and percent in each category; for continuous variables, the mean, median, standard deviation, quartiles and range (minimum, maximum). Typically, within-arm assessment of the change from the baseline measurement to a follow-up measurement will be analyzed using McNemar's test (for categorical response variables) or the paired t-test (for continuous variables). In general, when use of formal testing to assess differences between arms is required, the following methods will be used: for binomial response variables, chi-square tests and logistic regression; for continuous variables, t-tests and linear regression. To assess the adequacy of the randomization, participants will be compared for baseline characteristics including demographics, pelvic examination, and laboratory measurements using descriptive statistics.

10.8.1 Primary Safety Analysis

Incidence rates of safety and toxicity endpoints will be compared across the arms using Cox Proportional Hazards Models stratified by site with robust variance estimates.³³ For this analysis, a safety and toxicity endpoint is defined as the occurrence in a participant of any primary safety endpoint described in Section 10.2.1 during follow-up.

The above analysis only looks at the time until the first event in a participant. To include information about subsequent events, an analysis that allows recurring events in individual participants will be conducted. This analysis will be performed using the Andersen Gill Proportional Hazards Model stratified by site with robust variance estimates.

AEs will be analyzed using MedDRA preferred terms. The number and percentage of participants experiencing each specific AE will be tabulated by severity and by relationship to treatment regimen. For the calculations in these tables, each participant's AE will be counted once under the maximum severity or the strongest recorded causal relationship to study product.

All AEs will be grouped by body system and a *p*-value and confidence interval for the relative risk (active product: placebo) of each AE will be calculated, as well as the difference in rates between treatment groups (active product – corresponding placebo) and its confidence interval. To safeguard against too many “false positive” safety findings, the statistical significance of the *p*-values will be assessed after a multiplicity adjustment.³⁴ Finally, a listing of EAEs reported to the DAIDS Safety Office will provide

details of the event including severity, relationship to study product, onset, duration and outcome.

Boxplots of local laboratory values will be generated for baseline values and for values measured during the course of the study. Each boxplot will show the 1st quartile, the median, and the 3rd quartile. Outliers, or values outside the boxplot, will also be plotted. If appropriate, horizontal lines representing boundaries for abnormal values will be plotted.

Note that all of the above analyses will be conducted under the ITT principle. However, participants off study product and/or those who are non-adherent that are included in these analyses could potentially lower the rate of safety and toxicity endpoints in the active product arms. Therefore a 'per-protocol' analysis, where time off-product is excluded from the analysis, will be used to explore the sensitivity of the conclusions obtained with the safety analysis under the ITT principle.

10.8.2 Primary Effectiveness Analysis

The primary analysis will be performed under the ITT principle with time from randomization to seroconversion as the endpoint. Cox Proportional Hazards models stratified by site will be used to assess the effectiveness of the VR. Product effectiveness will be expressed as a percent reduction in the HIV-1 incidence rate (i.e., $100 \times [1 - (\text{active product HIV-1 infection rate} / \text{corresponding placebo HIV-1 infection rate})]$).

10.9 Analysis of Main Secondary Endpoints

10.9.1 Acceptability

Information about acceptability will be obtained from questionnaires in which the participants will rate acceptability on a combination of categorical and continuous scales. Continuous measures of acceptability will be compared across arms using a t-test while categorical measures will be compared using chi-squared tests. Additional exploratory analyses of acceptability will be conducted to compare the intersection of acceptability of the product in some areas versus others and to determine if an appropriate composite measure of acceptability can be constructed.

10.9.2 Adherence

The adherence analysis will include:

1. Estimation of VR expulsion and removal rates
2. Estimation of the cumulative duration of time that the ring is out of the vagina
3. Comparison between arms of the quantities estimated in 1 and 2
4. Estimation of trends over time in adherence rates
5. Exploration of reasons for ring removal

The primary adherence analysis will focus on 1-3 using descriptive statistics for within arm estimation and t-tests to compare means or bootstrap-based tests to compare medians across arms. Trends over time in adherence rates will be explored using generalized estimating equations (GEE). Reasons for ring removal will be tabulated.

10.9.3 Drug Resistance

Rates of drug resistance in women who seroconvert during the study will be estimated and compared across arms. Fisher's Exact test will be used to compare rates of drug resistance across the arms at single points in time. GEE will be used to explore trends in resistance over time.

10.9.4 Pharmacokinetics

Plasma and vaginally sampled fluid dapivirine concentrations, will be used to describe the steady-state dapivirine concentrations at specified times throughout the study. Relationships between research participant characteristics will be explored, including study site, height, weight, adherence, and medical co-morbidities. Participant-specific dapivirine concentrations in each biological matrix will be explored for relationship to seroconversion outcomes.

10.10 Missing Data

We are targeting a retention rate of 95% over the study period. Based on previous HIV Prevention Trials Network (HPTN) and MTN trials, we expect to have minimal missing data. In any situation with missing data, we will do appropriate secondary analyses that adjust for variables that may be related to the missingness mechanism. If missing data rates are higher than anticipated (over 10%), we will include covariates that are related to missingness in likelihood-based regression models. We will also perform sensitivity analyses to assess the potential impact of the missing data. These analyses will include imputing the data under the most extreme scenarios of information missingness, such as assuming everyone missing has an extreme value of the missing variable, and less informative imputation approaches.

11 DATA HANDLING AND RECORDKEEPING

11.1 Data Management Responsibilities

Study CRFs will be developed by the MTN SDMC in conjunction with the protocol team. Quality control reports and queries routinely will be generated and distributed by the SDMC to the study sites for verification and resolution. As part of the study activation process, each study site must identify all CRFs to be used as source documents. Study CRF data are transferred to the MTN SDMC, entered, and cleaned using the DataFax data management system.

11.2 Source Documents and Access to Source Data/Documents

All study sites will maintain source data/documents in accordance with Requirements for Source Documentation in DAIDS Funded and/or Sponsored Clinical Trials (<http://www.niaid.nih.gov/LabsAndResources/resources/DAIDSClinRsrch/Documents/sourcedocpolicy.pdf>) and the relevant appendix regarding source documentation (<http://www.niaid.nih.gov/LabsAndResources/resources/DAIDSClinRsrch/Documents/sourcedocappndx.pdf>).

Each IoR/designee will maintain, and store securely, complete, accurate and current study records throughout the study. In accordance with U.S. regulations, for the investigational product tested, the IoR/designee will maintain all study documentation for at least two years following the date of marketing approval for the indication in which they were studied. If no marketing application is filed, or if the application is not approved, the records will be retained for two years after the investigation is discontinued and the US FDA is notified.

Study records must be maintained on site for the entire period of study implementation. Thereafter, instructions for record storage will be provided by DAIDS. No study records may be moved to an off-site location or destroyed prior to receiving approval from DAIDS.

11.3 Quality Control and Quality Assurance

All study sites will conduct quality control and quality assurance procedures in accordance with Requirements for Clinical Quality Management Plans at DAIDS Funded and/or Supported Clinical Research Sites (<http://www.niaid.nih.gov/LabsAndResources/resources/DAIDSClinRsrch/Documents/qmppolicy.pdf><http://www.niaid.nih.gov/LabsAndResources/resources/DAIDSClinRsrch/Documents/qmppolicy.pdf>).

12 CLINICAL SITE MONITORING

Study monitoring will be carried out by Pharmaceutical Product Development, Inc. (PPD) (Wilmington, NC) in accordance with current DAIDS policies. Study monitors will visit the site to do the following:

- Review informed consent forms, procedures, and documentation
- Assess compliance with the study protocol, Good Clinical Practices (GCP) guidelines, and applicable regulatory requirements (US and non-US), including CFR Title 45 Part 46 and Title 21 Parts 50, 56, and 312
- Perform source document verification to ensure the accuracy and completeness of study data

- Verify proper collection and storage of biological specimens
- Verify proper storage, dispensing, and accountability of investigational study products
- Assess implementation and documentation of internal site quality management procedures
- Verify that current license/certification is available on site for study staff listed on the current FDA Form 1572, DAIDS IoRs, and Delegation of Responsibilities Log/Form.

The IoR/designee will allow study monitors to inspect study facilities and documentation (e.g., informed consent forms, clinic and laboratory records, other source documents, CRFs), as well as observe the performance of study procedures. The IoR/designee also will allow inspection of all study-related documentation by authorized representatives of the MTN CORE, SDMC, and NL; NIAID, FDA, IPM, OHRP and local and US regulatory authorities. A site visit log will be maintained at the study site to document all visits.

13 HUMAN SUBJECTS PROTECTIONS

13.1 Institutional Review Boards/Ethics Committees

Site investigators will make efforts to minimize risks to participants. Participants and study staff members will take part in a thorough informed consent process. Before beginning the study, the IoR will have obtained IRB/EC approval and the protocol will have been submitted to the FDA. The IoR will permit audits by the NIH, IPM, the FDA, OHRP, or any of their appointed agents.

13.2 Protocol Registration

Prior to implementation of this protocol, and any subsequent full version amendments, each site must have the protocol and the protocol consent forms approved, as appropriate, by their local IRB/ EC and any other applicable regulatory entity (RE). Upon receiving final approval, sites will submit all required protocol registration documents to the DAIDS Protocol Registration Office (DAIDS PRO) at the RSC. The DAIDS PRO will review the submitted protocol registration packet to ensure that all of the required documents have been received.

Site-specific informed consent forms (ICFs) *will not* be reviewed or approved by the DAIDS PRO, and sites will receive an Initial Registration Notification when the DAIDS PRO receives a complete registration packet. Receipt of an Initial Registration Notification indicates successful completion of the protocol registration process. Sites will not receive any additional notifications from the DAIDS PRO for the initial protocol registration. A copy of the Initial Registration Notification should be retained in the site's regulatory files.

Upon receiving final IRB/EC and any other applicable RE approval(s) for an amendment, sites should implement the amendment immediately. Sites are required to submit an amendment registration packet to the DAIDS PRO at the RSC. The DAIDS PRO will review the submitted protocol registration packet to ensure that all the required documents have been received. Site-specific ICF(s) *will not* be reviewed and approved by the DAIDS PRO and sites will receive an Amendment Registration Notification when the DAIDS PRO receives a complete registration packet. A copy of the Amendment Registration Notification should be retained in the site's regulatory files.

For additional information on the protocol registration process and specific documents required for initial and amendment registrations, refer to the current version of the DAIDS Protocol Registration Manual.

13.3 Study Coordination

IPM holds the Investigational New Drug (IND) application for this study. Copies of all regulatory documents submitted to this IND by IPM are forwarded to DAIDS for cross-referencing with other INDs for the study products. Assignment of all sponsor responsibilities for this study will be specified in a Clinical Trial Agreement executed by NIAID and IPM.

Study implementation will also be guided by a common study-specific procedures manual that provides further instructions and operational guidance on conducting study visits; data and forms processing; specimen collection, processing, and shipping; AE assessment, management and reporting; dispensing study products and documenting product accountability; and other study operations. Standardized study-specific training will be provided to all sites by the MTN CORE, SDMC, NL and other designated members of the Protocol Team.

Close coordination between protocol team members is necessary to track study progress, respond to queries about proper study implementation, and address other issues in a timely manner. The PSRT will address issues related to study eligibility and AE management and reporting as needed to assure consistent case management, documentation, and information-sharing across sites. Rates of accrual, adherence, follow-up, and AE incidence will be monitored closely by the team as well as the SMC.

13.4 Risk Benefit Statement

13.4.1 Risks

General

It is not expected that this trial will expose human subjects to unreasonable risk.

Pelvic examination and procedures may cause mild discomfort and/or vaginal bleeding or spotting. Phlebotomy may lead to discomfort, feelings of dizziness or faintness,

and/or bruising, swelling and/or infection. Disclosure of HIV and STI status may cause worry, sadness or depression. Disclosure of HIV-positive status has been associated with depression, suicidal ideation, and denial as well as social isolation. Trained counselors will be available to help participants deal with these feelings. Participation in clinical research includes the risks of loss of confidentiality and discomfort with the personal nature of questions when discussing sexual behaviors.

Participants at sites requiring partner notification in response to diagnosed STI or HIV infection could have problems in their relationships with their sexual partners. Participants also could have problems in their partner relationships associated with use of study product.

Use of the study VR may lead to vaginal symptoms, including irritation, increased discharge, and discomfort (including with vaginal intercourse). It is possible that a participant may have an allergic reaction to the study product.

Based on AEs reported among female participants in previous studies, dapivirine VRs may be associated with:

- Vaginal bleeding
- Headache
- Fatigue
- Vulvovaginal or genital itching
- Abdominal discomfort
- Abdominal pain
- Urinary incontinence
- Nausea
- Vaginal or genital discharge

As with any vaginally retained product, the possibility of toxic shock syndrome, although rare, exists.

Site staff will make every effort to protect participant privacy while in the study. Although study sites make every effort to protect participant privacy and confidentiality, it is possible that participants' involvement in the study could become known to others, and that social harms may result (i.e., because participants could become known as HIV-positive or at "high risk" for HIV infection). For example, participants could be treated unfairly or discriminated against, or could have problems being accepted by their families and/or communities.

13.4.2 Benefits

Participants in this study may experience no direct benefit. Participants and others may benefit in the future from information learned from this study. Specifically, information learned in this study may lead to the development of safe and effective interventions to prevent HIV transmission. Participants also may appreciate the opportunity to contribute to the field of HIV prevention research.

Participants will receive HIV/STI risk reduction counseling, HIV and STI testing, physical examination, pelvic examination, and routine laboratory testing. Participants will be provided STI treatment in accordance with WHO guidelines free of charge. In addition, STI testing, counseling and treatment, as well as HIV testing and counseling will be available for participants' partners. For other medical conditions identified as part of the study screening and/or follow-up procedures, participants will be referred to other sources of care available in their community. Some volunteers may have the opportunity to access expedient treatment and decreased morbidity due to early diagnosis and treatment of abnormalities identified during tests, examinations and referrals.

13.5 Informed Consent Process

Written informed consent will be obtained from each study participant prior to both screening and enrollment. Written informed consent also will be obtained for long-term specimen storage and possible future testing as well as for off-site clinic visits as needed. Neither consent for long-term specimen storage nor off-site study visits are required for study participation. In obtaining and documenting informed consent, the IoR and their designees will comply with applicable local and US regulatory requirements and will adhere to GCP and to the ethical principles that have their origin in the Declaration of Helsinki. Study staff must document the informed consent process in accordance with the Requirements for Source Documentation in DAIDS Funded and/or Sponsored Clinical Trials (<http://rsc.tech-res.com/policiesandregulations/>). Participants will be provided with copies of the informed consent forms if they are willing to receive them.

In addition to informed consent forms, the Protocol Team will work with study staff and community representatives to develop appropriate materials about the study and a standardized approach to the informed consent process to be implemented at all study sites, which will be detailed in the study-specific procedures manual.

The informed consent process will cover all elements of informed consent required by research regulations. In addition, the process specifically will address the following topics of importance to this study:

- The unknown safety and unproven efficacy of the study product
- Randomization and the importance of participants in both study groups to the success of the study
- The importance of adherence to the study visit and procedures schedule
- The potential medical risks of study participation (and what to do if such risks are experienced)
- The potential social harms associated with study participation (and what to do if such harms are experienced)
- The real yet limited benefits of study participation
- The distinction between research and clinical care
- The right to withdraw from the study at any time

13.6 Participant Confidentiality

All study procedures will be conducted in private, and every effort will be made to protect participant privacy and confidentiality to the extent possible. Each study site will implement confidentiality protections that reflect the local study implementation plan and the input of study staff and community representatives to identify potential confidentiality issues and strategies to address them. In addition to local considerations, the protections described below will be implemented at all sites.

All study-related information will be stored securely at the study site. All participant information will be stored in locked areas with access limited to study staff. All laboratory specimens, study data collection, and administrative forms will be identified by coded number only to maintain participant confidentiality. All records that contain names or other personal identifiers, such as locator forms and informed consent forms, will be stored securely. All local databases will be secured with password protected access systems. Forms, lists, logbooks, appointment books, and any other listings that link participants' identification numbers to identifying information will be stored in a separate, locked file in an area with limited access. Participants' study information will not be released without their written permission, except as necessary for review, monitoring, and/or auditing by the following:

- Representatives of the US Federal Government, including the US FDA, the US OHRP, NIH, and/or contractors of the NIH, and other local and US regulatory authorities
- Representatives of IPM
- Study staff
- Site IRBs/ ECs

13.7 Special Populations

13.7.1 Pregnant Women

Women who test positive for pregnancy at Screening or Enrollment Visits will not be eligible to participate in this study. Should a woman test positive for pregnancy after Enrollment, a product hold will be implemented but all follow-up visits will be completed and data collected per Section 7.5.2. A urine pregnancy test will be performed at scheduled study visits, and additionally at interim visits as indicated; the IoR/designee will temporarily discontinue study product among participants who test positive for pregnancy. During the informed consent process, women will be informed that the VR is not a method of contraception and the effects of the VR on a developing human fetus are unknown.

Animal studies have failed to demonstrate risk to the fetus, but there are no adequate and well-controlled studies in pregnant women completed to support their inclusion to date.

13.7.2 Children

The NIH has mandated that children be included in research trials when appropriate. This study meets “Justifications for Exclusion” criteria for younger children as set forth by the NIH. Specifically, “insufficient data are available in adults to judge potential risk in children” and “children should not be the initial group to be involved in research studies.” This study does not plan to enroll children under 18 years old.

13.8 Compensation

Pending IRB/EC approval, participants will be compensated for time and effort in this study, and/or be reimbursed for travel to study visits and time away from work. Site specific reimbursement amounts will be specified in the study informed consent forms.

13.9 Communicable Disease Reporting

Study staff will comply with local requirements to report communicable diseases including HIV-1 identified among study participants to health authorities. Participants will be made aware of reporting requirements during the informed consent process.

13.10 Access to HIV-related Care

13.10.1 HIV Counseling and Testing

HIV test-related counseling will be provided to all potential study participants who consent to undergo HIV-1 screening to determine their eligibility for this study, and to all enrolled participants at each follow-up HIV-1 testing time point. Testing will be performed in accordance with the algorithm in Appendix III. Counseling will be provided in accordance with standard HIV counseling policies and methods at each site and additionally will emphasize the unknown efficacy of the study products in preventing HIV-1 infection. In accordance with the policies of the NIH, participants must receive their HIV-1 test results to take part in this study. Condoms will be provided to participants throughout the duration of their participation.

13.10.2 Care for Participants Identified as HIV-Infected

Care for participants identified as HIV-infected is described in Section 9.6.

13.11 Study Discontinuation

This study may be discontinued at any time by NIAID, the MTN, IPM, the US FDA, the OHRP, other government or regulatory authorities, or site IRBs/ECs.

14 PUBLICATION POLICY

DAIDS/NIAID and MTN policies and a clinical trial agreement (CTA) between IPM and NIAID will govern publication of the results of this study. Any presentation, abstract, or manuscript will be submitted by the investigator to the MTN Manuscript Review Committee, DAIDS, National Institute of Mental Health (NIMH), and IPM for review prior to submission.

15 APPENDICES

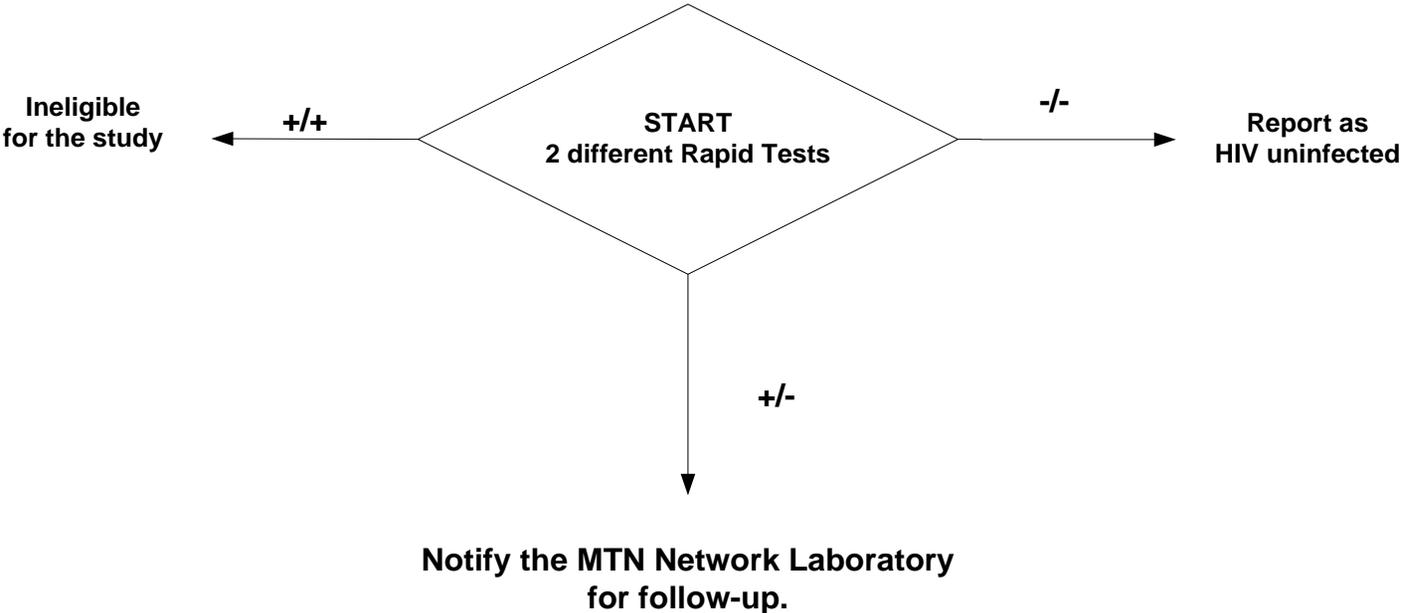
APPENDIX I: SCHEDULE OF STUDY VISITS AND EVALUATIONS

	SCR	ENR	Monthly Visits	Quarterly Visits	Semi-Annual Visits	PUEV	Study Exit/ Term Visit
ADMINISTRATIVE AND REGULATORY							
Obtain informed consent	X	X					
Assign a unique Participant Identification (PTID) number	X						
Assess and/or confirm eligibility	X	X					
Collect/review/update locator information	X	X	X	X	X	X	X
Randomization		X					
Provide reimbursement	X	X	X	X	X	X	X
Schedule next visit	*	X	X	X	X	X	*
BEHAVIORAL							
Contraceptive counseling	X	X	X	X	X		
Protocol adherence, including VR adherence counseling		X	X	X	X		
HIV/STI risk reduction counseling	X	X	X	X	X	X	X
HIV pre- and post-test counseling	X	X	X	X	X	X	X
Conduct a behavioral assessment includes sexual activity, condom use, and intravaginal practices		X		X	X	X	X
Conduct an adherence assessment			X	X	X	X	
Conduct an acceptability assessment				X	X	X	
Conduct social harms assessment				X	X	X	
CLINICAL							
Obtain/update medical and menstrual history	X	X	X	X	X	X	X
Obtain/update concomitant medications	X	X	X	X	X	X	X
Conduct a physical examination	X	X	*	X	X	X	
Perform a pelvic exam	X	X	*	*	X	X	*
Prescribe contraceptives	*†	*†	*†	*†	*†	*†	*†
Disclose available test results		X	X	X	X	X	X
Record/update AEs			X	X	X	X	X
Treat or prescribe treatment for UTIs/RTIs/STIs or refer for other findings	*	*	*	*	*	*	*
LABORATORY							
URINE	hCG	X	X	X	X	X	X
	Urine culture	*†	*†	*†	*†	*†	*†
	NAAT for GC/CT	X	*†	*†	*†	X	*†
BLOOD	HIV-1 Serology	X	X	X	X	X	X
	CBC with platelets	X			X	X	X
	Chemistries	X			X	X	X
	Syphilis serology	X		*	*	*	X
	Plasma		◊		X	X	X

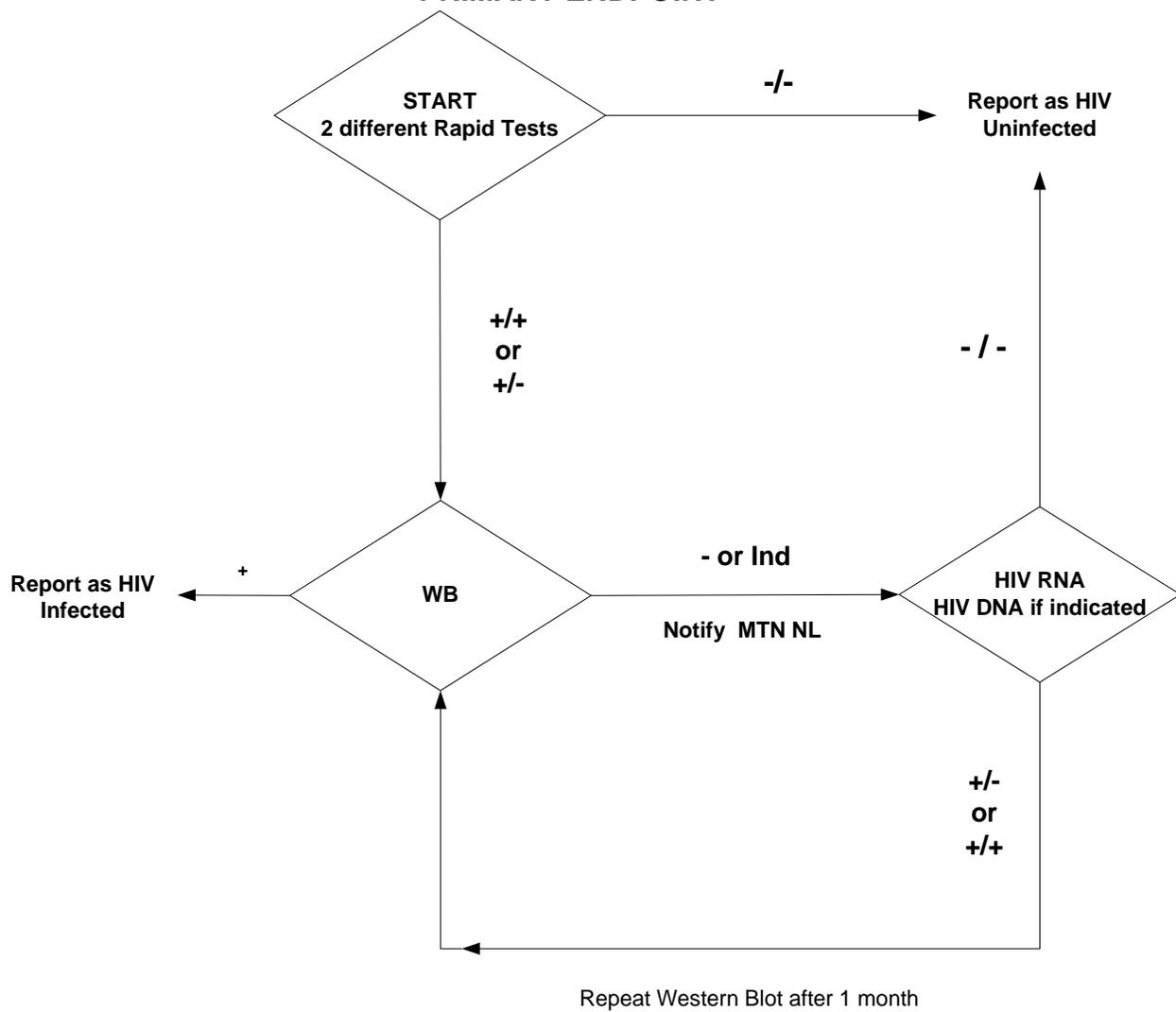
		<u>SCR</u>	<u>ENR</u>	<u>Monthly Visits</u>	<u>Quarterly Visits</u>	<u>Semi-Annual Visits</u>	<u>PUEV</u>	<u>Study Exit/ Term. Visit</u>
PELVIC	Rapid test for Trichomonas	X	*†	*†	*†	X	*†	*†
	Herpes lesion testing	*†	*†	*†	*†	*†	*†	*†
	Vaginal fluid pH	*†	X	*†	*†	X	X	*†
	KOH wet mount for candidiasis	*†	*†	*†	*†	*†	*†	*†
	Saline wet mount for BV	*†	*†	*†	*†	*†	*†	*†
	Gram stain		X			X	X	
	Vaginal fluid			X	X	X	X	X
	Pap Smear interpretation	*					X	
	Endocervical swab		X			X	X	
STUDY PRODUCT/ SUPPLIES								
	Provision of study specified condoms	X	X	X	X	X	X	X
	Provision of study VR instructions		X	*	*	*		
	Provision of one study VR for insertion		X	X	X	X		
	Participant or clinician/designee to remove used study VR			X	X	X	X	
	Digital exam(s) by clinician to check VR placement		X	∞*	*	*		
	Demonstrated attempt to remove and reinsert the ring		X					
	Collection of used study VR			X	X	X	X	
	Dispense a bottle of water, at select sites with capacity		*	*	*	*		

X mandatory, * If indicated, † per local standard of care, ∞= for archive, ∞= required at Month 1

APPENDIX II: ALGORITHM FOR HIV ANTIBODY TESTING- SCREENING/ENROLLMENT



APPENDIX III: ALGORITHM FOR HIV ANTIBODY TESTING FOR FOLLOW-UP AND PRIMARY ENDPOINT



Ind: Indeterminate test results

APPENDIX IV: SAMPLE INFORMED CONSENT DOCUMENT (SCREENING)

SAMPLE INFORMED CONSENT FORM DIVISION OF AIDS, NIAID, NIH

MTN-020

A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring Containing Dapivirine for the Prevention of HIV-1 Infection in Women

A Study to Prevent Infection with a Ring for Extended Use (ASPIRE)

Version 1.0

PRINCIPAL INVESTIGATOR: *[Sites to insert]*

PHONE: *[Sites to insert]*

INFORMED CONSENT

This is a screening consent form, you are being asked to volunteer for screening tests to find out if you are eligible for a research study known as MTN-020: ASPIRE, *A Study to Prevent Infection with a Ring for Extended Use*. This study is for sexually active women between the ages of 18 and 45 years old. Approximately 3476 women will be in this study across many clinics in multiple countries in Africa. This Microbicide Trials Network (MTN) study is sponsored by the US National Institutes of Health (NIH). The products being used in this study include a dapivirine vaginal ring and a placebo vaginal ring; these products will be explained later in this document. These rings are supplied by the International Partnership for Microbicides (IPM). The person in charge of this study at this clinic is [INSERT NAME OF PRINCIPAL INVESTIGATOR]. Before you decide if you want to screen for this study, we want you to learn about the study.

Screening exams and tests, which include interview questions, urine, and blood tests, a physical exam and an exam of your vagina, will be performed to better understand your health. The study staff will explain the exams and tests to you and what is expected of you.

YOUR PARTICIPATION IS VOLUNTARY

This consent form gives information about the screening tests that will be discussed with you. Once you understand the screening tests, and if you agree to take part, you will be asked to sign your name on this form. You will be offered a copy of this form to keep. Before you learn about the screening tests, it is important that you know the following:

- You are only being asked to have the screening tests at this time. Even if you agree to have the screening tests, you do not have to join this study.
- Your participation is voluntary; you do not have to have the screening tests if you do not want to participate in this study
- Some people may not be able to join this study because of information found during the screening tests.
- You may decide not to have the screening tests, or to withdraw from the screening tests at any time, without losing your regular medical care.

- If you decide not to have the screening tests, you can still join another research study later, if one is available and you qualify. However, you cannot join the ASPIRE study if you are currently or have recently taken part (in the past 60 days) in another study that used drugs, medical devices or vaginal products.
- If you participated in the VOICE study or any other HIV prevention study using antiretroviral medications (pills or gel), within 12 months of your enrollment visit, you are not eligible to join ASPIRE
- You are asked to tell the study staff about any other studies you are taking part in, or thinking about taking part in. This is very important for your safety.
- You will receive the results of the screening tests even if you are not eligible to join this study.
- If new information is learned about the study, or the study product, you will be told about this as soon as possible.

PURPOSE OF THE SCREENING TESTS AND THE STUDY

The main purpose of these screening exams and tests is to find out if you can join this research study. This research study will try to find out if a vaginal ring containing the medicine dapivirine is safe and effective in preventing the transmission of HIV-1. A vaginal ring is a flexible ring that may or may not contain the study drug, dapivirine. Researchers do not yet know if this ring will work in humans to protect against HIV. This is why we are doing this research. Women will place a ring in the vagina monthly for approximately 12-24 months; however this period could be shorter or longer than anticipated.

STUDY PRODUCTS

There are two different rings that will be used in this study. The first is a vaginal ring containing dapivirine. Dapivirine vaginal rings have been previously tested and found to be generally safe and well-tolerated in women. This study is testing whether a vaginal ring containing dapivirine can help to prevent the spread of HIV. HIV is the virus that causes AIDS. Drugs being tested by researchers to prevent HIV infection work in different ways. Dapivirine works by preventing HIV from making copies of itself, thereby stopping the spread of HIV in the body. The other ring in this study is a placebo vaginal ring, a placebo is a product that has no study drug in it.

The most effective way to protect against getting HIV infection during sex is to use a condom every time you have sex. The staff can provide you additional information about other ways to avoid getting HIV infection that work along with condoms.

STUDY GROUPS

If you meet the study requirements and if you decide to enroll in MTN-020, you will be in one of two vaginal ring study groups; dapivirine vaginal ring or placebo vaginal ring. Approximately 3476 women will be in this study, half of the women who participate in the study will receive a placebo vaginal ring the other half will receive the dapivirine vaginal ring. Women will be assigned to a group by random chance, like flipping a coin. Neither the women participating in this study nor the staff can decide which ring will be selected or know which ring participants have received.

Both of the study groups are important to this study. No matter which study group you are in, you must remember that we do not know if the dapivirine ring works to protect women from getting HIV.

WHAT DO I HAVE TO DO IF I DECIDE TO TAKE PART IN THE SCREENING EXAMS AND TESTS?

If you agree to have screening tests, they can be done today. Ideally, all procedures are completed today. However if you have to come back to complete this visit, some procedures may need to be repeated. If you enroll in the study, you will have visits every month at *[sites to specify where visits will take place]*.

Screening Visit:

If you agree, your first visit will happen today. Study staff will help you understand this form and answer your questions before you sign it. The procedures done at this visit will take about *[sites to insert time]*.

- You will be asked questions about where you live and other questions about you, your medical health (including what medications you are taking), menstrual history, your sexual and vaginal practices and other questions to ensure you are eligible for this study. You will also be asked questions to make sure that you understand the study requirements.
- Study staff will:
 - Perform a physical exam
 - Talk with you about the requirements of the study including using an effective method of contraception throughout your participation in this study
 - Test your urine for:
 - Infections passed through sex
 - Pregnancy
 - If you are pregnant you cannot join this study for the safety of your baby. If the study is still open after your pregnancy, you may come back here to find out if you are eligible.
 - Talk about ways to avoid becoming pregnant, such as contraception.
 - Take a blood sample *[Sites to insert amount]*:
 - To test the health of your blood, liver and kidneys
 - To test for infections passed through sex, including HIV
 - You will be told your HIV test result as soon as it is available. You will talk with the study staff about the meaning of your results, how you feel about them, and ways to prevent HIV and other sexually transmitted infections. Sometimes HIV tests are not clearly positive, but also not clearly negative. In that case, we will do more tests until we know your results for sure. You must receive your HIV test results to be in the study. If the test shows you have HIV, you cannot join the study. We will tell you where you can get care and other services you may need. The study staff will tell you about other studies you may be eligible for, if any.
 - If you are not HIV positive you will talk with study staff about HIV, HIV testing, and ways to avoid HIV and other infections passed through sex.
 - Perform a pelvic examination:
 - The study doctor or nurse will use a speculum, a plastic or metal instrument used to separate the walls of the vagina. The study doctor or nurse will look at your

vagina and cervix for signs of infection, and other problems. They may also take some fluids to test for other possible problems if they feel it is necessary.

- The study staff may also collect samples from your cervix for a “Pap test”. If the test shows a problem, it could mean you should have more tests. If you have a written report confirming a normal Pap test in the past 12 months or if you had an abnormal Pap test but had follow-up indicating no treatment was required, you will not need to have a Pap test during this visit.
- Give you treatment or refer you for treatment for infections passed through sex, if needed.
- Tell you about other services if you need them
- Provide you with the results of your tests, if available
- Provide you with male condoms
- Schedule your next visit to enroll in MTN-020, if you are eligible and willing

Results of tests listed above will be available within [*Sites to specify timeframe*] of your visit. If you decide not to join MTN-020, no blood collected at this visit will be kept or used for any tests other than those listed above. The study staff will review your test results with you when they are available. If the results show you can join the ASPIRE study, the study staff will explain the study to you and answer any questions you have. If you decide to be in this study, you will be asked to sign another consent form.

RISKS AND/OR DISCOMFORTS

Risks of Blood Draws: You may feel discomfort or pain when your blood is drawn. You may feel dizzy or faint. You may have a bruise, swelling, small clot, or infection where the needle goes into your hand or arm.

Risks of Genital Exams: You may feel discomfort or pressure during the examination of your genital area and inside your vagina. You may have a small amount of vaginal bleeding which will stop shortly after the examination.

Other Possible Risks: You may become embarrassed or worried when discussing your sexual practices, ways to protect against HIV and other infections passed through sex. You may become worried while waiting for your test results. If you have HIV or other infections, learning this could make you angry, depressed or worried. Trained study counselors will help you deal with any feelings or questions you have.

We will make every effort to protect your privacy and confidentiality while you are having the screening tests. Your visits will take place in private. However, it is possible others may learn of your participation here and, because of this, may treat you unfairly or discriminate against you. For example, you could have problems getting or keeping a job, or being accepted by your family or community. Finding out your HIV status could also cause problems between you and your partner. If you have any problems, study counselors will talk with you and/or your partner to try to help resolve them.

BENEFITS

You may receive no direct benefit from the screening tests. However, you will have a physical examination, pelvic examination, and tests to check on the health of your blood, liver, and kidneys. If these tests show that you might have health problems, you will be told where to get medical care and other services available to you.

You will be counseled and tested for infections passed through sex. If you have these infections, you may be offered treatment for them, if needed. If you are infected with HIV, you will be told about medical care, counseling, and other available services that could be of help to you. For other health problems that cannot be treated at this clinic, the study staff will refer you to other places where you may receive medical care. If your Pap test result shows anything that is not normal, you will be referred for advice and/or treatment.

REASONS WHY YOU MAY BE WITHDRAWN FROM THE SCREENING TESTS WITHOUT YOUR CONSENT

You may be withdrawn from the screening tests without your consent if:

- You are found to not be eligible for this study
- The study is stopped or canceled
- The study staff feel that having the screening tests would be harmful to you
- You are not willing to find out your HIV test result
- You are not able to attend clinic visits or complete the screening tests
- Other reasons are identified by study staff

COSTS TO YOU

[Site to complete according to site capacity] There is no cost to you for screening tests. Treatments available to you from the study site for infections passed through sex (other than HIV) will either be given to you free of charge or you will be referred for treatment while you are screening for this study.

REIMBURSEMENT

[Sites to insert information about local reimbursement:] You will receive [Sites to insert amount \$xx] for your time, effort, and travel to and from the clinic at each scheduled screening visit.

CONFIDENTIALITY

Efforts will be made to keep your personal information confidential. However, it is not possible to guarantee confidentiality. Your personal information may be disclosed if required by law. The study staff will use your personal information, if needed, to verify that you are not taking part in any other research studies. This includes studies conducted by other researchers that study staff knows about. Any publication of this study will not use your name or identify you personally.

Your records may be reviewed by:

- Representatives of the US Federal Government, including the US FDA, US Office for Human Research Protections (OHRP), NIH, and/or contractors of NIH
- [Insert applicable local authorities, e.g., Ministry of Health, medicine control authority]
- IPM, the organization that supplies the study rings
- Study monitors
- Site Institutional Review Board (IRB)/ Ethics Committee (EC), an Ethics Committee is a committee that watches over the safety and rights of research participants
- Study staff

[Sites to include/amend the following:] [LOCAL/STATE/NATIONAL] regulations require study staff to report the names of people who test positive for HIV and other infections passed during sex to the [LOCAL HEALTH AUTHORITY]. Outreach workers from the [HEALTH AUTHORITY] may then contact you about informing your partners, since they also should be tested. If you do not want to inform your partners yourself, the outreach workers will contact them, according to the confidentiality guidelines of the [HEALTH AUTHORITY].

The researchers will do everything they can to protect your privacy.

RESEARCH-RELATED INJURY

[Sites to specify institutional policy:] It is unlikely that you will be injured as a result of having the screening tests. This US federally funded study does not have the ability to provide compensation for research-related injury. If you are injured or become ill from taking part in this study, it is important to tell your study doctor. Emergency treatment may be available but you or your insurance company will be charged for this treatment. You do not give up any legal rights by signing this consent form.

PROBLEMS OR QUESTIONS

If you ever have any questions about the screening tests, or if you have a research-related injury, you should contact *[insert name of the investigator or other study staff]* at *[insert telephone number and/or physical address]*.

If you have questions about your rights as a research participant, you should contact *[insert name or title of person on the IRB/EC or other organization appropriate for the site]* at *[insert physical address and telephone number]*.

If you have questions about who to contact at the research site, you should contact *[insert name of the investigator or community educator or community advisory board (CAB) member]* at *[insert physical address and telephone number]*.

SIGNATURES

[Insert signature blocks as required by the local IRB/EC:] If you have read this consent form, or had it read and explained to you, and you understand the information, and you voluntarily agree to have the screening tests, please sign your name below.

Participant Name (print)	Participant Signature	Date
-----------------------------	-----------------------	------

Study Staff Conducting Consent Discussion (print)	Study Staff Signature	Date
---	-----------------------	------

Witness Name (print)	Witness Signature	Date
-------------------------	-------------------	------

APPENDIX V: SAMPLE INFORMED CONSENT DOCUMENT (ENROLLMENT)

SAMPLE INFORMED CONSENT FORM DIVISION OF AIDS, NIAID, NIH

MTN-020

A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring Containing Dapivirine for the Prevention of HIV-1 Infection in Women

A Study to Prevent Infection with a Ring for Extended Use (ASPIRE)

Version 1.0

PRINCIPAL INVESTIGATOR: *[Sites to insert]*

PHONE: *[Sites to insert]*

INFORMED CONSENT

You are being asked to take part in MTN-020: ASPIRE, *A Study to Prevent Infection with a Ring for Extended Use*. This study is for sexually active women between the ages of 18 and 45 years old. Approximately 3476 women will be in this study across many clinics in multiple countries in Africa. This Microbicide Trials Network (MTN) study is sponsored by the US National Institutes of Health (NIH). The products being used in this study include a dapivirine vaginal ring and a placebo vaginal ring; these products will be explained later in this document. These rings are supplied by the International Partnership for Microbicides (IPM). The person in charge of this study at this clinic is [INSERT NAME OF PRINCIPAL INVESTIGATOR]. Before you decide if you want to join this study, we want you to learn about the study. The study staff will talk with you about the study and answer your questions. You may decide not to join or to withdraw from the study at any time.

YOUR PARTICIPATION IS VOLUNTARY

Once you read, discuss, and understand the study, and if you agree to take part, you will be asked to sign your name on this form. You will be offered a copy of this form to keep.

PURPOSE OF THE STUDY

This research study will try to find out if a vaginal ring containing the drug dapivirine is safe and effective in preventing the transmission of HIV-1. Researchers do not yet know if this ring will work in humans to protect against HIV. This is why we are doing this research. Women will place a ring in the vagina monthly for approximately 12 months to 24 months. The vaginal rings used in this study are flexible rings that may or may not contain the study drug, dapivirine.

STUDY PRODUCTS

There are two different rings that will be used in this study. The first is a vaginal ring containing dapivirine. Dapivirine vaginal rings have been previously tested and found to be generally safe and well-tolerated in women. This study is testing whether a vaginal ring containing dapivirine can help to prevent the spread of HIV. HIV is the virus that causes AIDS. Drugs being tested by researchers to prevent HIV infection work in different ways. Dapivirine works by preventing HIV from making copies of itself, thereby stopping the spread of HIV in the body. The other ring in this study is a placebo vaginal ring; a placebo is a product that has no study drug in it.

The most effective way to protect against getting HIV infection during sex is to use a condom every time you have sex. The staff can provide you additional information about other ways to avoid getting HIV infection that work along with condoms.

STUDY GROUPS

If you meet the study requirements, and, if you decide to enroll in MTN-020, you will be in one of two vaginal ring study groups; dapivirine vaginal ring or placebo vaginal ring. A placebo vaginal ring is a ring that will look like the other rings but has no medicine in it. Approximately 3476 women will participate in this study, half of the women will be in each study group and women will be assigned to a group by random chance, like flipping a coin. Neither the women participating in this study nor the staff can decide which ring will be selected or know which ring participants have received.

You will be asked to place a ring in your vagina monthly and not remove it for a month; a study clinician can help you to insert the ring if you are unable to do so. After one month, you or the study clinician will remove the ring and replace it with a new ring. The ring should not be worn beyond 35 days, unless you are told otherwise by study staff. This will last for approximately 12-24 months; however this period could be shorter or longer than anticipated.

Both of the study groups are important to this study. No matter which study group you are in, you must remember that we do not know if the dapivirine ring works to protect women from getting HIV.

WHAT DO I HAVE TO DO IF I DECIDE TO TAKE PART IN THE ASPIRE STUDY?

If you decide to enroll in the study, some procedures will occur today. After today you will be in the study for 13-25 months. You will have a visit here today (Day 0), and monthly for up to 25 months. As previously mentioned, you will use a vaginal ring for 12- 24 months and after the ring is removed you will have a final study visit approximately 4 weeks after you finish using the ring to check on your health. Study visits may be required beyond the final study visit to monitor your health. Procedures done at these visits will take approximately *[site to insert]*.

You will be randomly assigned by study staff to one of two study groups. Neither you nor study staff will know which group you are in, choose your group or change the group you have been placed into. Women in the study groups will have the same study visit schedule.

You will be asked to:

- Confirm you are able to join the study and that you understand the study requirements
- Answer questions about your vaginal practices, including sexual activity
- Provide information about where you live and how we can contact you or update study staff with this information
- Describe any changes in your health (including what medicines you are taking) and your menstrual periods
- Describe any health problems or other problems having to do with the study including the vaginal ring since your last visit, except at your Enrollment Visit

You will be asked to use a study vaginal ring; as part of using this ring you will:

- Talk with study staff about how to properly wear and use the study ring, including information about wearing the ring during menses, how to clean the ring if it falls out, etc.

- Receive and, if you are able, insert a new study ring at each visit. If you are not able a study clinician may help you insert/remove the study ring.
- Have an exam to ensure the ring is properly inserted.
- Return your vaginal ring to study staff
- *[The following may be omitted based upon local water quality:]* Receive a bottle of water to take home to wash off the ring in the event it falls out, if you are in a location where clean water is scarce and if you need it
- In the event that the ring falls out, you may return to the clinic to have the ring reinserted if you are uncomfortable doing so yourself
- Answer questions about your experience using the vaginal ring, including whether or not the ring was removed from or fell out of your vagina. Answer questions about any problems you may have had during your participation in this study. Also, you may be asked questions about vaginal practices that may affect how the study drug is absorbed by your body. Answer questions that may make you uncomfortable, such as drug use. You may use a computer to answer these questions or a staff member may ask you these questions. It is important that you know that you will answer these questions in private and your responses will be kept confidential.

You will be asked to have the following clinical procedures performed:

- A physical exam
- Provide a sample of blood [insert amount] to:
 - Check the health of your blood, liver and kidneys
 - Test for HIV. You will be told your HIV test result as soon as it is available. You will talk about the meaning of your results and how you feel about them, and ways to prevent HIV and other STIs. Sometimes HIV tests are not clearly positive, but also not clearly negative. In that case, we will do more tests until we know your results for sure. You must receive your HIV test results to be in the study. If the test shows you have HIV, you cannot join the study. We will tell you where you can get care and other services you may need. You will be told about other studies you may be eligible for, if any.
 - If you were to become infected with HIV these samples would be processed to see how much study product is absorbed by your body.
- Provide a urine sample to:
 - Check to see if you are pregnant
 - Test for infections passed through sex
- Provide vaginal fluid samples:
 - To see how much study product is absorbed by your body at all of your study visits. We will test these samples only in the event that you become infected with HIV.

- A pelvic examination twice a year. The study doctor or nurse will use a speculum. A speculum is a plastic or metal instrument used to separate the walls of the vagina. It is used so the doctor or nurse can examine the vagina and the cervix during the exam. They will check for signs of infection, and other problems. They may also take some fluids to test for STIs and other possible problems if they feel it is necessary
 - The study staff may also collect samples from your cervix for a “Pap test”. If the test shows a problem, it could mean you should have more tests. This will be performed at your Product Use End Visit.

As part of the clinical procedures you will:

- Receive the results of your tests when available
- Learn about other services available to you
- Receive treatment or be referred for treatment for problems that the study staff may find.
- Receive counseling. You will discuss:
 - Sexually transmitted infections (STIs), HIV, HIV/STI testing, and ways to prevent HIV and other infections passed through sex
 - The rules of the study and how to follow the rules (except at your Final Visit)
 - Contraception and ways to prevent getting pregnant (except at your Final Visit)
- Receive male condoms
- You will schedule your next visit (except at your Final Visit)

At any time during the study, the following may need to be collected if you are having symptoms or if clinicians suspect you may have an infection:

- Have vaginal and/or cervical swabs collected to test for infections
- Have a blood sample [Sites to insert amount] collected to test:
 - For infections passed through sex
 - For HIV
 - The health of your blood, liver and kidneys
- Have urine collected to test for:
 - Pregnancy
 - Infection

It may be necessary for you to make additional visit(s) during your participation in this study to have any of the study procedures listed above repeated in the event of unforeseen or unanticipated abnormal results; difficulties in sample shipping, processing, or testing; and/or if you experience any changes in your physical condition.

If you leave the study early, you will be asked to complete a final evaluation.

If you become infected with HIV

Your participation in this study will not cause HIV infection. However, there is always a chance that through sexual activity or other activities you may become HIV-positive. In the event you become HIV-positive, study staff will counsel and refer you for medical care and other available

services. You will continue to be counseled while you are in this study. You will have more tests to find out which drugs would be appropriate for your type of HIV-1 (HIV drug resistance). If the HIV tests confirm that you have been infected with HIV, you will stop using the ring, but we will ask you to continue to come into the clinic for regularly scheduled visits for some of the study procedures. You may be referred to other research studies.

It may be necessary, depending upon local and national health requirements, for study staff to report diseases, including HIV, identified among ASPIRE study participants. The reportable diseases at this site are [Sites to insert].

RISKS AND/OR DISCOMFORTS

Risks of Blood Draws: You may feel discomfort or pain when your blood is drawn. You may feel dizzy or faint. You may have a bruise, swelling, small clot, or infection where the needle goes into your hand or arm.

Risks of Genital Exams: You may feel discomfort or pressure during the examination of your genital area and inside your vagina. You may have a small amount of vaginal bleeding which will stop shortly after the examination.

Risks of Study Rings

The study rings can cause some side effects, such as an allergic reaction. We do not yet know all the side effects of the rings. Some, but not all women who used the rings in other studies have had:

- Discharge from the vagina
- Vaginal irritation and discomfort

As with any product that is placed into the vagina, the possibility of toxic shock syndrome exists. Toxic shock syndrome is a serious but uncommon infection caused by bacteria. While it is unlikely that you should experience toxic shock syndrome as a result of using the vaginal ring, it is important that you alert the study staff if you experience any symptoms associated with toxic shock syndrome, i.e., sudden high fever, a faint feeling, diarrhea, headache, a rash, and muscle aches.

Risks of Study Drugs

Based on side effects reported among women in previous studies, dapivirine vaginal rings may be associated with:

- Vaginal bleeding
- Headache
- Fatigue
- Vulvovaginal or genital itching
- Abdominal discomfort
- Abdominal pain
- Urinary incontinence
- Nausea
- Vaginal or genital discharge

Other Possible Risks

It is possible that you may develop HIV drug resistance which means that drug resistant HIV will continue to replicate in the presence of the drug to which it has become resistant and using this

product could make it difficult to use dapivirine or drugs like it to treat HIV. Drug resistance only occurs if you were to become infected with HIV.

You may become embarrassed and/or worried when discussing your sexual practices, ways to protect against HIV and other infections passed through sex, and your test results. You may be worried while waiting for your test results. If you have HIV or other infections, learning this could make you worried. Finding out your HIV status could also cause problems between you and your partner. Trained study counselors will help you deal with any feelings or questions you have.

We will make every effort to protect your privacy and confidentiality during the study visits. Your visits will take place in private. However, it is possible that others may learn of your participation here and, because of this, may treat you unfairly or discriminate against you. For example, you could have problems getting or keeping a job, or being accepted by your family or community. If you have any problems, study counselors will talk with you and/or your partner to try to help resolve them.

Some other studies of HIV prevention have found an unexpected higher risk of getting HIV among study participants. This could happen in any prevention study, including the MTN-020. Because of this, the study staff will remind you of the importance of using condoms to protect against HIV.

BENEFITS

No one knows if the study ring will prevent HIV infection. Information learned from this study may help in the development of ways to prevent the spread of HIV in the future. You will receive pelvic exams and counseling and testing for HIV and STIs. You will also have tests to check the overall health of your liver, kidneys, and blood cells.

This study cannot provide you with general medical care, but study staff will refer you to other available sources of care.

You will be counseled and tested for HIV and STIs. You will receive free male condoms, if you need them. If you are infected with HIV, you will be referred for medical care, counseling, and other services available to you. Medical care for HIV infection will not be part of this study. You will need to receive care for HIV infection from your own health care provider or we will provide you with a referral. If you have an STI diagnosed, you will receive medicine or a referral, if needed.

Pregnancy

The ring with dapivirine and the placebo ring are not birth control. You must agree to use an effective method of birth control such as birth control pills or another hormonal-based method (except for vaginal rings), or an intrauterine device (IUD), unless you are sterilized.

We do not know what effect the study drugs have on pregnancy, including the effect of the study drug on the fetuses of women who use the vaginal ring when pregnant. Because of this, pregnant women may not join this study. Women who join the study must agree to use effective contraception and have scheduled pregnancy tests while in the study.

If you become pregnant during the study, study staff will refer you to available medical care and other services you or your baby may need. The study does not pay for this care. You will stop using the ring, but we may ask you to keep coming here for study visits as originally planned.

We will change the study procedures as needed to protect your health while you are pregnant. *[Sites to include/amend the following: We may also contact you to find out about the health of your pregnancy, and the health of your baby up to one year old, if you have a baby. We may also contact you about a study that collects information about pregnancy and babies up to one year old.]* The outcome of your pregnancy is important to study staff; therefore your pregnancy will be followed until the results of your pregnancy are known.

NEW INFORMATION

You will be told any new information learned during this study that might affect your willingness to stay in the study. For example, if information becomes available that shows that the ring may be causing bad effects, you will be told about this. It is important for you to know that other drugs are being tested for HIV prevention. HIV prevention researchers working on this study are committed to providing you with any data that becomes available, regardless of the product if it is found to be effective in preventing HIV. You will also be told when study results may be available, and how to learn about them.

WHY YOU MAY STOP TAKING THE STUDY DRUG EARLY OR BE WITHDRAWN FROM THE STUDY WITHOUT YOUR CONSENT

A study doctor may need to remove you from the study early without your permission if:

- The study is cancelled by the US FDA, US NIH, International Partnership for Microbicides, the US Office for Human Research Protections (OHRP), MTN, the local government or regulatory agency, Data Safety Monitoring Board (DSMB), or the Institutional Review Board (IRB)/ the Ethics Committee (EC). An IRB/EC is a committee that watches over the safety and rights of research participants
- The Study Monitoring Committee (SMC) recommends that the study be stopped early. (A SMC reviews the progress of the study and the kinds of effects that people report while they are participating in the study)
- You are not able to keep appointments
- Other reasons that may prevent you from completing the study successfully

The study doctor will ask you to stop using the study vaginal ring but continue to come in for your follow-up visits and procedures if:

- You become pregnant
- You become infected with HIV
- A study doctor decides that using the vaginal ring would be harmful to you
- You require a treatment that you may not take while using the study vaginal ring
- You have a bad reaction to the study vaginal ring

If a study doctor asks you to stop using the ring, you will need to come in for all scheduled visits described above, including the physical examination, vital signs, and blood tests. You will stop using study ring until the study doctor decides it is safe for you to start using it again, if possible.

In the event that you are removed from or choose to leave this study, you will be asked to return your vaginal ring. If you do not have the vaginal ring with you at the time of your contact with staff, staff members will make every effort to assist you in returning the ring as soon as possible. *[Sites to specify allowances for special circumstances.]*

ALTERNATIVES TO PARTICIPATION

There are no gels, pills or vaginal rings currently available to protect against HIV during sex. **The only known way to protect against HIV during sex that is available is to use a condom every time you have sex.**

[Sites to include/amend the following if applicable: There may be other studies going on here or in the community that you may be eligible for. If you wish, we will tell you about other studies that we know about. There also may be other places where you can go for HIV counseling and testing and contraception. We will tell you about those places if you wish.]

COSTS TO YOU

[Site to complete according to site capacity] There is no cost to you for study related visits, the vaginal ring, physical examinations, laboratory tests or other procedures. Treatments available to you from the study site for infections passed through sex (other than HIV) will be given to you free of charge or you will be referred for available treatment for the duration of the study.

REIMBURSEMENT

[Sites to insert information about local reimbursement:] You will receive *[Sites to insert amount \$xx]* for your time, effort, and travel to and from the clinic at each scheduled visit. You may receive *[Sites to insert amount \$xx]* for any visits which occur in between your normally scheduled visits.

CONFIDENTIALITY

Efforts will be made to keep your information confidential. However, it is not possible to guarantee confidentiality. Your personal information may be disclosed if required by law. The study staff may use your personal information to verify that you are not in any other research studies. Any publication of this study will not use your name or identify you personally.

Your records may be reviewed by:

- Representatives of the US Federal Government, including the US FDA, US Office for Human Research Protections (OHRP), NIH, and/or contractors of NIH
- *[Insert applicable local authorities, e.g., Ministry of Health, medicine control authority]*
- IPM, the organization that supplies the study rings
- Study monitors
- Site Institutional Review Board (IRB)/ Ethics Committee (EC), an Ethics Committee is a committee that watches over the safety and rights of research participants
- Study staff

[Sites to include/amend the following:] [LOCAL/STATE/NATIONAL] regulations require study staff to report the names of people who test positive for HIV and other infections passed during sex to the [LOCAL HEALTH AUTHORITY]. Outreach workers from the [LOCAL HEALTH AUTHORITY] may then contact you about informing your partners, since they also should be tested. If you do not want to inform your partners yourself, the outreach workers will contact them, according to the confidentiality guidelines of the [HEALTH AUTHORITY].

The researchers will do everything they can to protect your privacy.

RESEARCH-RELATED INJURY

[Sites to specify institutional policy:] It is unlikely that you will be injured as a result of study participation. This US federally funded study does not have the ability to provide compensation for research-related injury. If you are injured or become ill from taking part in this study, it is

important to tell your study doctor. Emergency treatment may be available but you or your insurance company will be charged for this treatment. You do not give up any legal rights by signing this consent form.

YOUR RIGHTS AS A RESEARCH PARTICIPANT/VOLUNTEER

[Sites to specify institutional policy:] Taking part in this study is completely voluntary. You may choose not to take part in this study or leave this study at any time. If you choose not to participate or to leave the study, you will not lose the benefit of services to which you would otherwise be entitled at this clinic. If you want the results of the study after the study is over, let the study staff members know.

PROBLEMS OR QUESTIONS

If you ever have any questions about the study, or if you have a research-related injury, you should contact *[insert name of the investigator or other study staff]* at *[insert telephone number and/or physical address]*.

If you have questions about your rights as a research participant, you should contact *[insert name or title of person on the IRB/EC or other organization appropriate for the site]* at *[insert physical address and telephone number]*.

SIGNATURES

[Sites to insert signature/initial blocks as required by the local IRB/EC:]

[Sites to omit the following if a separate consent for Storage and Future Testing of Specimens is required]

CONSENT FOR STORAGE AND FUTURE TESTING OF SPECIMENS

There might be a small amount of blood, vaginal and cervical fluids left over after we have done all of the study related testing after your study visits. We would like to ask your permission to store your leftover blood, vaginal and cervical fluids for testing in future studies. You can still enroll in this study if you decide not to have blood, vaginal and cervical fluids stored for future studies. If you do not want the blood, vaginal and cervical fluids stored, we will destroy the left over specimens. Any future studies that may be done will also have to be approved by an Ethics Committee/ Institutional Review Board. You can withdraw your consent for the storage and future testing of specimens at any time by providing your request in writing to the person in charge of this study.

Initials and Date

I DO agree to allow my biological specimens and health data to be stored and used in future research studies.

Initials and Date

I DO NOT agree to allow my biological specimens and health data to be stored and used in future research studies.

CONSENT FOR OFF-SITE VISITS

Members of the research team at this clinic may be able to visit you at your home or at another location as part of the study. Some of the scheduled study visits may take place at your home or other location outside of the research clinic, if you agree. The study personnel will explain in greater detail the requirements of these visits (like the conditions of the place, the type of visit and the duration of it) and the procedures to maintain your information in a confidential manner. However it is important that you know that off site visits may eventually affect your confidentiality even if the study staff take precautions not to disclose the purpose of the visits.

To conduct visits outside of the clinic we will need you to authorize us to do so, please read carefully the following statement and initial and date one option. Choosing not to be visited outside of the study clinic will not affect your participation in this study. You can withdraw your consent for the storage and future testing of specimens at any time by providing your request in writing to the person in charge of this study.

_____ I DO agree to be visited at a location other than the study clinic by clinic staff, when necessary
Initials and Date

_____ I DO NOT agree to be visited at a location other than the study clinic by clinic staff, when necessary
Initials and Date

If you have read this consent form, or had it read and explained to you, and you understand the information, and you voluntarily agree to have the study, please sign your name below.

_____	_____	_____
Participant Name (print)	Participant Signature	Date

_____	_____	_____
Study Staff Conducting Consent Discussion (print)	Study Staff Signature	Date

_____	_____	_____
Witness Name (print)	Witness Signature	Date

REFERENCES

1. United Nations Programme on HIV/AIDS (UNAIDS) Report on the Global AIDS Epidemic 2010.
(http://www.unaids.org/en/media/unaids/contentassets/documents/factsheet/2010/20101123_FS_SSA_em_en.pdf) accessed 20 April 2011.
2. Elias CJ, Coggins C. Female-controlled methods to prevent sexual transmission of HIV. *AIDS* 1996;10:S43-S51.
3. Rerks-Ngarm S, Pitisuttithum P, Nitayaphan S, et al. Vaccination with ALVAC and AIDSVAX to prevent HIV-1 infection in Thailand. *The New England journal of medicine* 2009;361:2209-20.
4. Abdool Karim Q, Abdool Karim SS, Frohlich JA, et al. Effectiveness and safety of tenofovir gel, an antiretroviral microbicide, for the prevention of HIV infection in women. *Science* 2010;329:1168-74.
5. Grohskopf L, Gvetadze R, Pathak S, et al. Preliminary analysis of biomedical data from the phase II clinical safety trial of tenofovir disoproxil fumarate (TDF) for HIV-1 pre-exposure prophylaxis (PrEP) among U.S. men who have sex with men (MSM). XVIII International AIDS Conference (AIDS 2010). Vienna, July 18-23, 2010. Abstract FRLBC102.
6. Grant RM, Lama JR, Anderson PL, et al. Preexposure chemoprophylaxis for HIV prevention in men who have sex with men. *N Engl J Med*;363:2587-99.
7. NIAID Bulletin. The FEM-PrEP HIV Prevention Study and Its Implications for NIAID Research.
(<http://www.niaid.nih.gov/news/newsreleases/2011/Pages/FEMPrEP.aspx>) Accessed 20 April 2011.
8. Chabbert-Buffet N, Ouzounian S, Kairis AP, Bouchard P. Contraceptive applications of progesterone receptor modulators. *Eur J Contracept Reprod Health Care* 2008;13:222-30.
9. Nel AM, Smythe SC, Habibi S, Kaptur PE, Romano JW. Pharmacokinetics of 2 dapivirine vaginal microbicide gels and their safety vs. Hydroxyethyl cellulose-based universal placebo gel. *J Acquir Immune Defic Syndr* 2010;55:161-9.
10. Nel AM, Coplan P, Smythe SC, et al. Pharmacokinetic assessment of dapivirine vaginal microbicide gel in healthy, HIV-negative women. *AIDS Res Hum Retroviruses* 2010;26:1181-90.
11. Romano J, Variano B, Coplan P, et al. Safety and availability of dapivirine (TMC120) delivered from an intravaginal ring. *AIDS Res Hum Retroviruses* 2009;25:483-8.
12. Nel AM, Coplan P, van de Wijgert JH, et al. Safety, tolerability, and systemic absorption of dapivirine vaginal microbicide gel in healthy, HIV-negative women. *Aids* 2009;23:1531-8.
13. Nel A, Smythe S, Young K, et al. Safety and pharmacokinetics of dapivirine delivery from matrix and reservoir intravaginal rings to HIV-negative women. *J Acquir Immune Defic Syndr* 2009;51:416-23.
14. Fletcher P, Harman S, Azijn H, et al. Inhibition of human immunodeficiency virus type 1 infection by the candidate microbicide dapivirine, a nonnucleoside reverse transcriptase inhibitor. *Antimicrob Agents Chemother* 2009;53:487-95.

15. Jespers VA, Van Roey JM, Beets GI, Buve AM. Dose-ranging phase 1 study of TMC120, a promising vaginal microbicide, in HIV-negative and HIV-positive female volunteers. *J Acquir Immune Defic Syndr* 2007;44:154-8.
16. Anderson RM, Swinton J, Garnett GP. Potential impact of low efficacy HIV-1 vaccines in populations with high rates of infection. *Proc Biol Sci* 1995;261:147-51.
17. IPM. Investigator's Brochure: Dapivirine Vaginal Ring. 13 July 2011.
18. Di Fabio S, Van Roey J, Giannini G, et al. Inhibition of vaginal transmission of HIV-1 in hu-SCID mice by the non-nucleoside reverse transcriptase inhibitor TMC120 in a gel formulation. *Aids* 2003;17:1597-604.
19. IPM. Investigator's Brochure: Dapivirine Vaginal Gel. 23 September 2010.
20. Nel A, Smythe S, Young K, Malcolm K, Rosenberg Z, Romano J. Safety and Pharmacokinetic Assessment of 28 Day Anti-HIV Dapivirine Intravaginal Microbicide Rings In: CROI. Boston; 2008.
21. Sellors JW, Nieminen P, Vesterinen E, Paavonen J. Observer variability in the scoring of colpophotographs. *Obstet Gynecol* 1990;76:1006-8.
22. Brache V, Faundes A. Contraceptive vaginal rings: a review. *Contraception* 2010;82:418-27.
23. Novak A, de la Loge C, Abetz L, van der Meulen EA. The combined contraceptive vaginal ring, NuvaRing: an international study of user acceptability. *Contraception* 2003;67:187-94.
24. Pharmacia & Upjohn Estrin® Physician Leaflet. (http://www.pfizer.com/pfizer/download/uspi_estrin.pdf).
25. Warner Chilcott Femring® Full U.S. Prescribing Information. ([http://www.warnerchilcott.com/pdfs/pi-femring\(physician\).pdf](http://www.warnerchilcott.com/pdfs/pi-femring(physician).pdf)).
26. Warner Chilcott Femring® Patient Information Materials: Patient Acceptability. ([http://www.warnerchilcott.com/pdfs/pi-femring\(patient\).pdf](http://www.warnerchilcott.com/pdfs/pi-femring(patient).pdf)).
27. Boily MC, Masse BR, Desai K, Alary M, Anderson RM. Some important issues in the planning of phase III HIV vaccine efficacy trials. *Vaccine* 1999;17:989-1004.
28. Chen FH. The impact of microbicides and changes in condom usage on HIV prevalence in men and women. *Aids* 2006;20:1551-3.
29. Abbas UL, Anderson RM, Mellors JW. Potential impact of antiretroviral chemoprophylaxis on HIV-1 transmission in resource-limited settings. *PLoS One* 2007;2:e875.
30. Fleming T, Harrington D. Counting process and survival analysis. New York: Wiley-Interscience, 1991.
31. Abdool Karim SS, Richardson BA, Ramjee G, et al. Safety and effectiveness of BufferGel and 0.5% PRO2000 gel for the prevention of HIV infection in women. *AIDS (London, England)* 2011;25:957-66.
32. Thio CL, Sulkowski MS, Thomas DL. Treatment of chronic hepatitis B in HIV-infected persons: thinking outside the black box. *Clin Infect Dis* 2005;41:1035-40.
33. Levy V, Grant RM. Antiretroviral therapy for hepatitis B virus-HIV-coinfected patients: promises and pitfalls. *Clin Infect Dis* 2006;43:904-10.
34. Mehrotra DV, Heyse JF. Use of the false discovery rate for evaluating clinical safety data. *Stat Methods Med Res* 2004;13:227-38.

Letter of Amendment #01 to:

MTN-020

DAIDS Document ID: 11840

A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring Containing Dapivirine for the Prevention of HIV-1 Infection in Women

Version 1.0 / 28 September 2011
IND# 110,659

Letter of Amendment date: November 7, 2011

Site Instruction

The following information impacts the MTN-020 study and must be forwarded to your Institutional Review Board (IRB)/Ethics Committee (EC) as soon as possible for their information and review. This must be approved by your IRB/EC before implementation.

The following information also impacts the sample informed consent. Your IRB/EC will be responsible for determining the process of informing subjects of the contents of this letter of amendment.

Implementation

Upon receiving final IRB/EC and any other applicable Regulatory Entity (RE) approval(s) for this LoA, sites should implement the LoA immediately. Sites are still required to submit an LoA registration packet to the DAIDS Protocol Registration Office (PRO) at the Regulatory Support Center (RSC). Sites will receive a registration notification for the LoA once the DAIDS PRO verifies that all the required LoA registration documents have been received and are complete. An LoA registration notification from the DAIDS PRO is not required prior to implementing the LoA. A copy of the LoA registration notification along with this letter and any IRB/EC correspondence should be retained in the site's regulatory files.

Summary of Revisions

This LoA does not impact the overall design or the study visit schedule for MTN-020. The primary reason for this LoA is to clarify the timing of pelvic exam schedule, samples to be collected and tests to be completed on vaginal samples collected. Also the collection of plasma and testing for CD4+ T cell count and HIV-1 RNA PCR after seroconversion has been clarified. The Clinical Research Products Management Center (CRPMC) has been removed from the protocol as study product will not be routed through the CRPMC. Other minor edits to the List of Abbreviations and Acronyms and updates to the Protocol Team Roster have been incorporated.

With the exception of the modifications to the Protocol Team Roster, text to be deleted is noted by strikethrough and text to be added is noted below in bold font.

Detailed Listing of Revisions

1. The following updates are made to the Protocol Team Roster:

Added:

Jennifer M. Berthiaume, MPH, MSW
Project Coordinator
FHCRC – SCHARP
1100 Fairview Ave. North, LE-400
P.O. Box 19024
Seattle, WA 98109-1024
Phone: 206-667-1230
Fax: 206-667-4812
Email: jberthia@scharp.org

Liza Noonan, PhD
Protocol Statistician
FHCRC – SCHARP
1100 Fairview Ave. North, M2-C200
P.O. Box 19024
Seattle, WA 98109-1024 USA
Phone: 206-667-7130
Fax: 206-667-4812
Email: liza@fhcrc.org

Rachel Scheckter, MPH, IBCLC
Prevention Research Specialist
 FHI 360
 P.O. Box 13950
 Research Triangle Park, NC 27709 USA
 Phone: 919-544-7040 Ext. 11392
 Fax: 919-544-7261
 Email: rscheckter@fhi360.org

Updated:

Scharla Estep, RPh, MS
PAB Pharmacist
 DAIDS, Pharmaceutical Affairs Branch
 6700 B Rockledge Dr., Room 4111
 Bethesda, MD 20817 USA
 Phone: 301-435-3746
 Fax: 301-402-1506
 Email: sr72v@nih.gov

Ashley Mayo, MPH
Clinical Research Manager
 FHI 360
 P.O. Box 13950
 Research Triangle Park, NC 27709 USA
 Phone: 919-544-7040 Ext. 11164
 Fax: 919-544-7261
 Email: amayo@fhi360.org

- Study products for MTN-020 will not be routed through the Clinical Research Products Management Center. Section 6.4.3, Accountability, first paragraph has been modified accordingly. In addition, the List of Abbreviations and Acronyms has been updated to reflect the protocol change:

Section 6.4.3, Accountability:

Each CRS Pharmacist of Record (PoR) is required to maintain complete records of all study products received from the ~~NIAID Clinical Research Products Management Center (CRPMC)~~ and subsequently dispensed. All unused study products must be returned to the MTN Pharmacist after the study is completed or terminated unless otherwise instructed by the MTN Pharmacist. The procedures to be followed are provided in the MTN-020 Pharmacy Manual.

List of Abbreviations and Acronyms:

~~CRPMC~~ ~~Clinical Research Products Management Center~~

- Edits are made to Table 4, *Screening Visit*, Table 5, *Enrollment Visit*, Table 6, *Follow-up Visits*; and Table 8, *Study Exit/Termination Visit* and Appendix I, and Appendix IV, *Sample Informed Consent Document (SCREENING)*, to clarify the timing of the pelvic exams and the schedule for Gram stain, Endocervical swab, and Vaginal fluid pH collection.

Table 4: Screening Visit:

Screening Visit		
Component		Procedures
Laboratory	Pelvic	<ul style="list-style-type: none"> • Collect pelvic specimens <ul style="list-style-type: none"> – Rapid test for Trichomonas – Gram stain – Endocervical swab – Herpes lesion testing* † – Vaginal fluid pH* † – Potassium hydroxide (KOH) wet mount for candidiasis* † – Saline wet mount for <i>Bacterial vaginosis</i> (BV)* † – Pap smear interpretation*

* if indicated, † per local standard of care

Table 5: Enrollment Visit:

Enrollment Visit		
Component		Procedures
Clinical		<ul style="list-style-type: none"> • Update medical and menstrual history • Update concomitant medications • Provide contraceptives* † • Conduct a physical examination • Perform a pelvic exam* † • Disclosure of available test results • Treat or prescribe treatment for UTIs/RTIs/STIs or refer for other findings*
Laboratory	Pelvic	<ul style="list-style-type: none"> • Collect pelvic specimens* † <ul style="list-style-type: none"> – Gram stain – Vaginal fluid pH* † – Endocervical swab – Rapid test for Trichomonas* † – Herpes lesion testing* † – KOH wet mount for candidiasis* † – Saline wet mount for BV* †

* if indicated, † per local standard of care

Table 6: Follow-up Visits: Monthly, Quarterly, Semi-Annually

Follow-up Visits: Monthly, Quarterly, Semi-Annually		
Component		Procedures
Clinical		<ul style="list-style-type: none"> • Review/update medical and menstrual history • Review/update concomitant medications • Provide contraceptives* † • Perform physical examination ◐* • Perform pelvic examination for the collection pelvic specimens and to assess local safety ◑* † • Disclosure of available test results • Record/update AEs • Treat or prescribe treatment for UTIs/RTIs/STIs or refer for other findings*

◐ = to be completed at all quarterly visits (Months 3, 6, 9, etc.), ◑ = to be completed at all semi-annual visits only (Months 6, 12, 18, etc.), * if indicated, † per local standard of care

Table 8: Study Exit/Termination Visit

Study Exit/ Termination Visit		
Component		Procedures
Clinical		<ul style="list-style-type: none"> • Review/update medical and menstrual history • Review/update concomitant medications • Provide contraceptives* † • Disclosure of available test results • Perform pelvic examination* † • Record/update AEs • Treat or prescribe treatment for UTIs/RTIs/STIs or refer for other findings*

* if indicated, † per local standard of care

Appendix I: Schedule of Study Visits and Evaluations:

	SCR	ENR	Monthly Visits	Quarterly Visits	Semi-Annual Visits	PUEV	Study Exit/Term. Visit
CLINICAL							
Perform a pelvic exam	X	X*†	*†	*†	X	X	*†
LABORATORY							
PELVIC	Rapid test for Trichomonas	X	*†	*†	*†	X	*†
	Herpes lesion testing	*†	*†	*†	*†	*†	*†
	Vaginal fluid pH	*†X	X*†	*†	*†	X	X
	KOH wet mount for candidiasis	*†	*†	*†	*†	*†	*†
	Saline wet mount for BV	*†	*†	*†	*†	*†	*†
	Gram stain	X	X			X	X
	Vaginal fluid			X	X	X	X
	Pap Smear interpretation	*					X
	Endocervical swab	X	X			X	X

X mandatory, * If indicated, † per local standard of care, ‡ for archive, ▣= required at Month 1

Appendix IV: Sample Informed Consent Document (SCREENING), *What Do I Have To Do If I Decide To Take Part In The Screening Exams and Tests, Screening Visit* subsection, first sentence has been modified:

- o The study staff may also collect samples from your cervix for **testing, including a “Pap test”**. [...]
4. Section 7.5.1, *Participants Who Become Infected with HIV-1*, the first bullet has been replaced to allow for the collection of plasma and testing for CD4+ T cell count and HIV-1 RNA PCR at the first opportunity available to study staff after a positive rapid is observed, in addition Appendix V, *Sample Informed Consent (ENROLLMENT)*, has been updated to reflect the additional testing:

Section 7.5.1, *Participants Who Become Infected with HIV-1*:

- ~~The visit (scheduled or interim) at which the participant is given her Western Blot or HIV RNA/DNA test results confirming her HIV infection~~
- **Upon each instance of positive HIV rapid test(s) during follow-up**

Appendix V, *Sample Informed Consent (ENROLLMENT)*, *If you become infected with HIV* subsection, first paragraph has been modified:

Your participation in this study will not cause HIV infection. However, there is always a chance that through sexual activity or other activities you may become HIV-positive. ~~In the event you become HIV-positive, study staff will counsel and refer you for medical care and other available services. You will continue to be counseled while you are in this study.~~ **If the HIV tests confirm that you have been infected with HIV, you will stop using the ring, but we will ask you to continue to come into the clinic for regularly scheduled visits for some of the study procedures.** You will have more blood tests at 1, 3, 6 and every six months after your HIV infection is discovered to find out which drugs would be inappropriate for your type of HIV-1 (HIV drug resistance), **the amount of immune protection in your blood (CD4+ T-cell count), and the amount of HIV in your blood (viral load).** ~~If the HIV tests confirm that you have been infected with HIV, you will stop using the ring, but we will ask you to continue to come into the clinic for regularly scheduled visits for some of the study procedures.~~ You may be referred to other research studies. **If you join another study it may not be necessary to collect additional blood for testing.** ~~In the event you become HIV-positive, study staff will counsel and refer you for medical care and other available services while you are in this study.~~

5. Edits to Appendix V: Informed Consent Document (Enrollment) clarify the testing planned for the vaginal fluid testing. These edits have been incorporated into the *WHAT WILL I HAVE TO DO IF I AGREE TO TAKE PART IN THIS RESEARCH STUDY* section:
- Provide vaginal fluid samples:
 - To see how much study product is ~~absorbed~~ **retained** by your ~~body~~ **vagina and indicators of safety** at all of your study visits. ~~We will test these samples only in the event that you become infected with HIV~~

The above information will be incorporated into the next version of the protocol at a later time if it is amended.

Letter of Amendment #02 to:

MTN-020

DAIDS Document ID: 11840

A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring Containing Dapivirine for the Prevention of HIV-1 Infection in Women

Version 1.0 / 28 September 2011

Letter of Amendment date: 19 April 2012

Site Instruction

The following information impacts the MTN-020 study and must be forwarded to your Institutional Review Board (IRB)/Ethics Committee (EC) as soon as possible for their information and review. This must be approved by your IRB/EC before implementation.

The following information also impacts the sample informed consent. Your IRB/EC will be responsible for determining the process of informing subjects of the contents of this Letter of Amendment (LoA).

Implementation

Upon receiving final IRB/EC and any other applicable Regulatory Entity (RE) approval(s) for this LoA, sites should implement the LoA immediately. Sites are still required to submit an LoA registration packet to the DAIDS Protocol Registration Office (PRO) at the Regulatory Support Center (RSC). Sites will receive a registration notification for the LoA once the DAIDS PRO verifies that all the required LoA registration documents have been received and are complete. An LoA registration notification from the DAIDS PRO is not required prior to implementing the LoA. A copy of the LoA registration notification along with this letter and any IRB/EC correspondence should be retained in the site's regulatory files.

Summary of Revisions

This LoA does not impact the overall design or the study visit schedule for MTN-020. This LoA corrects the Investigational New Drug (IND) number listed on the cover page, offers minor clarifications to Section 6.0, Study Product, affords the continuation of vaginal procedures in women who become pregnant, clarifies the timing of vaginal fluid collection, allows for additional tests to be completed on vaginal rings and allows for flexibility regarding the completion of quantitative behavioral assessments in participants who discontinue study product use. In addition, the protocol has been modified to allow for the completion of in-depth interviews and focus group discussions. Other modifications include, the incorporation of required language to accommodate the FDA Final Rule regarding trial registration within the Sample Informed Consent(s) and clarification of language in the Enrollment Sample Informed Consent. Minor edits to the List of Abbreviations and Acronyms along with updates to the Protocol Team Roster have been incorporated.

With the exception of the modifications to the Protocol Team Roster, text to be deleted is noted by strikethrough and text to be added is noted below in bold font.

Section 2: Implementation

1. The following edit has been made to the cover page of MTN-020:

IND# ~~440,659~~**108,743**

2. The following updates are made to the Protocol Team Roster-

Added:

Linda-Gail Bekker, MBChB, PhD
Site Investigator
 Desmond Tutu HIV Foundation, IIDMM
 University of Cape Town
 Cape Town, 7705 South Africa
 Phone: 27-21-650-6959
 Fax: 27-21-650-6963
 E-mail: Linda-Gail.Bekker@hiv-research.org.za

Gonasagrie Nair, MBChB
Site Investigator
 CAPRISA - eThekweni CRS
 3 Richards Road
 Durban 4001 South Africa
 Phone: 27-31-260-1972
 Fax: 27-31-307-7119
 Email: nairg1@ukzn.ac.za

Karen Isaacs
Sr. Clinical Research Manager
 FHI 360
 P.O. Box 13950
 Research Triangle Park, NC 27709 USA
 Phone: 919-544-7040 Ext. 11488
 Fax: 919-544-7261
 Email: kisaacs@fhi360.org

Elizabeth Montgomery, MHS, PhD
BWRG Representative
 RTI International
 114 Sansome Street, Suite 500
 San Francisco, CA 94104 USA
 Phone: 310-837-2772
 Fax: 310-841-2772
 Email: emontgomery@rti.org

Sharavi Gandham, MS
MTN SDMC Statistical Research Associate
 FHCRC-SCHARP
 1100 Fairview Avenue North, M2-C200
 PO Box 19024
 Seattle, WA 98109-1024 USA
 Phone: 206-667-5676
 Fax: 206-667-4378
 Email: sharavi@ssharp.org

The following individual has been removed from the Protocol Team Roster: Liza Noonan, PhD.

3. Edits to Section 6.1, *Regimen*, second paragraph, second sentence, clarify that the maximum length of time a vaginal ring may be inserted in the vagina:

The VR should be worn for approximately 28 consecutive days at a time ~~but~~ **and it is recommended for** not more than 35 days before being replaced.

4. Edits to Section 6.4.3, *Accountability*, first paragraph, last sentence clarify the proper name for the MTN-020 Pharmacist Study Product Management Procedures Manual:

The procedures to be followed are provided in the MTN-020 **Pharmacyist Study Product Management Procedures Manual**.

5. Edits to Section 6.4.4, *Retrieval of Study Product*, Table 3: *Retrieval of Study Product*, second row, reflect product hold guidelines:

Permanent discontinuation due to severe (Grade 3 or higher) renal or hepatic toxicity	Within 5 working days
---	-----------------------

6. Edits to Section 6.4.4, *Retrieval of Study Product*, fourth paragraph, clarify procedures for ring retrieval:

If prolonged use (greater than 35 days) of the study VR has occurred, **attempts should be made to contact the participant and retrieve the study product** ~~must be retrieved~~.

- Edits to Section 6.4.4, *Retrieval of Study Product*, fifth paragraph, second sentence, clarify when study staff should arrange to collect the study VR if not retrieved at the Study Exit/Termination Visit:

If the participant does not bring her remaining supplies to this visit, study staff must arrange to retrieve the VR within **25** business days.

- Edits have been made to Section 7.3, *Enrollment Visit (Day 0)* and Appendix I: *Schedule of Study Visits and Evaluations* to clarify that collection of vaginal fluid should occur at Enrollment:

Section 7.3, *Enrollment*:

Laboratory	Pelvic	<ul style="list-style-type: none"> Collect pelvic specimens <ul style="list-style-type: none"> Vaginal fluid
-------------------	---------------	--

Appendix I: *Schedule of Study Visits and Evaluations, Laboratory, Pelvic* subheading:

	<u>SCR</u>	<u>ENR</u>	<u>Monthly Visits</u>	<u>Quarterly Visits</u>	<u>Semi-Annual Visits</u>	<u>PUEV</u>	<u>Study Exit/Term. Visit</u>
Vaginal fluid		X	X	X	X	X	X

- Edits have been made in Section 7.5.2, *Participants Who Become Pregnant*, second bullet, to allow for the continuation of vaginal procedures:
 - Pelvic examinations, including vaginal fluid collection, after 24 weeks of pregnancy, **unless participants indicate comfort with continuing vaginal procedures. See SSP Manual for additional guidance.**
- Edits have been made to Section 7.5.3, *Participants Who Temporarily Hold or Permanently Discontinue Study Product Use*, see new second paragraph:

In the event that a participant permanently discontinues study product early, the Adherence and Acceptability Assessments will be administered according to guidance provided from the protocol team, see MTN-020 SSP Manual for additional guidance.

- Edits have been made to allow for the completion of in-depth interviews and focus group discussions with a subset of participants to the list of *Acronyms and Abbreviations*, Section 5, *Study Population*, Section 7.7, *Behavioral Evaluations*, 13.4.1, *Risks*, and Appendix V, *Sample Informed Consent Document (Enrollment)*:

The following text has been added to the list of *Acronyms and Abbreviations*:

IDI	in-depth interview
FGD	focus group discussion

Section 5, *Study Population*, after 5.4 *Co-enrollment Guidelines*, a new subsection has been added:

5.5 Selection of Participants for In-depth Interviews and Focus Group Discussions

A subset of participants will be eligible for participation in in-depth interviews or focus group discussions regarding their trial experiences and use of the study products as outlined in Section 7.7.

Section 7.7, *Behavioral Evaluations*, below the third bullet, the following text has been added:

In a subset of participants the aforementioned behaviors will be further explored via in-depth interviews (IDI) and focus group discussions (FGDs). Approximately 35-40 participants per site, who agree to participate in the subset, and who have been selected for either IDI and/or FGD participation, will be asked to complete up to three IDIs and/or one FGD at select sites.

Section 7.7, *Behavioral Evaluations, Adherence Assessments* subsection, a second paragraph has been added:

The IDI and/or FGD subset will discuss a range of topics with trained interviewers/facilitators, such as potential challenges to VR use (e.g., novelty of device, use during menses and sex, dual use with contraceptives, other reproductive issues), partner and significant others' knowledge of study

participation and reaction to VR use, other topics related to adherence to the VR, and special issues relevant to VR use and VR adherence (e.g., motivation to join the trial, timing and circumstances around early study and/or product termination, etc.).

Section 7.7, *Behavioral Evaluations, Acceptability Assessments* subsection, a second paragraph has been added:

The IDI and/or FGD subset may include discussion of the following topics with trained interviewers; perceived benefits of VR use, willingness to use VR in the future, and practical issues of VR use in the “real world” (e.g., access, storage, disposal, insertion and removal, etc.), community attitudes towards the product, and other topics of interest related to acceptability of the VR.

Section 7.7, *Behavioral Evaluations, Sexual activity, condom use and intravaginal practices* subsection, a second paragraph and a new subsection have been added:

The IDI and/or FGD subset may include discussion of the following topics with trained interviewers/facilitators; the impact of VR use on sexual activity, condom use, and intravaginal practices, and other topics of interest related to sexual activity, condom use, and intravaginal practices.

In-Depth Interview and Focus Group Discussion Procedures

The IDIs and FGDs will be conducted in an appropriate meeting room that is conducive to the number of participants, confidentiality and privacy, and the need to audio-record the session. The FGDs and IDIs will be conducted at a time and location that allows for a neutral and comfortable environment. IDI and FGD participants will be greeted and staff will be available to fully explain the IDI and FGD process and answer any questions. The facilitator will then initiate the IDI and/or FGD by first explaining that the session will be audio-recorded and later transcribed and, if necessary, translated. Ground rules for conduct will be described (e.g., no interruptions, cell phones, confidentiality). The facilitator will then conduct the session by following the appropriate IDI or FGD guide. IDI and FGDs guides will be structured, but will allow opportunity for probing and exploration of spontaneously generated themes. Participants in the FGDs will be asked to use pseudonyms for themselves and for anyone they may talk about. A staff member will take notes during the session as a back-up to the audio-recording, and to record non-verbal information. The audio recording, notes, and analyses from these materials will be kept confidential.

Section 13.4.1, *Risks*, new seventh paragraph:

Participation in research includes the risks of loss of confidentiality and discomfort with the personal nature of questions. Participants who participate in the FGDs may disclose what other participants said during the discussion. All FGD participants will be asked and strongly encouraged to respect each other’s confidentiality. Furthermore, all FGD participants will be asked to use pseudonyms for themselves and for anyone they may talk about during the course of the FGD.

Section 13.6, *Participant Confidentiality*, second paragraph, the sentences were added after the sixth sentence:

All digital audio files will be stored on password-protected computers. Audio files will be transcribed. Please see SSP for guidance regarding audio file destruction.

Appendix V: *Sample Informed Consent Document (Enrollment), WHAT DO I HAVE TO DO IF I DECIDE TO TAKE PART IN THE ASPIRE STUDY?*, immediately preceding the *If you leave the study early, you will be asked to complete a final evaluation* subsection the following text has been added:

[Sites participating in the IDI and FGD Subset please insert the following language:]

Additional Study Activities (Optional)

You may also be asked to participate in a few optional study activities. If you choose to participate, you will be asked questions about your use of the ring, your preferences and opinions, your experiences with using the ring during sex, and any problems you may have had using the ring. Approximately 35-40 women at this site will be asked questions either in a group or individually. If you are asked and decide to accept to participate in these additional study activities, you will be compensated for your time and effort. You do not have to agree to participate in these activities to join this study. The interviews will be audio-recorded to make sure to record your words exactly

how you said them. The voice recordings will be destroyed as soon as the audio recording has been typed and checked. The audio recording, notes, and analyses from these materials will be kept confidential and will only use study numbers or fake names. This means that no one other than the MTN-020 study team will have access to your responses. The information that links you to the research materials will be kept in a secure location that will be accessed only by members of the MTN-020 study team for the purposes of this research.

In-depth Interview(s) and Group Discussions

You may be asked to participate in one, two, or three interview(s) with a trained staff member or you may be asked to participate in a group discussion with other study participants about opinions that you or other participants have. If you choose to participate, you will be asked to discuss your use of the study product, your feelings about the study product and trial participation, and other questions that can help researchers to better understand participants' experiences while taking part in the study. These discussions will last about one hour.

_____ **Yes, I agree to participate in in-depth interviews or group discussions**
Initials & Date

_____ **No, I do not want to participate in in-depth interviews or group discussions**
Initials & Date

Appendix V: *Sample Informed Consent Document (Enrollment)*, *WHAT DO I HAVE TO DO IF I DECIDE TO TAKE PART IN THE ASPIRE STUDY?* section, *Other possible risks* sub-section, the following text has been added:

[Sites participating in the IDI and FGD Subset please insert the following language:]

If you choose to participate in the group discussion, other participants will hear what you say. We will not reveal your full name to other participants. We will also ask every participant not to tell anyone outside of the group what any person said during the discussion. While it is not at all likely that your discussion will be made public, we cannot guarantee that everyone will keep the discussion private.

12. Edits have been made to Section 6.5, *Adherence Counseling and Assessment*, Section 7.4.1, *Monthly, Quarterly, Semi-Annual Study Visits*, Section 7.4.2, *Product Use End Visit (PUEV)*, Section 7.9, *Laboratory Evaluations*, Appendix I: *Schedule of Study Visits and Evaluation*, Section 10.9.2, *Adherence* and Appendix V: *Sample Informed Consent Document (Enrollment)* to allow for additional testing on returned vaginal rings:

Section 6.5, *Adherence Counseling and Assessment*, *Assessment* sub-section, new second paragraph:

Laboratory testing may be performed on returned vaginal rings to assess participant adherence.

In Section 7.4.1, *Monthly, Quarterly, Semi-Annual Study Visits*, Table 6: *Follow-up Visits: Monthly, Quarterly, Semi-Annually* and Section 7.4.2, *Product Use End Visit (PUEV)*, Table 7: *PUEV, Laboratory, Pelvic* sub-section a new line item was added:

- **VR adherence assessment(s), if indicated**

Section 7.9, *Laboratory Evaluations*, new sub-section added:

Study Product

- **Study VR adherence assessment(s), if indicated**

Section 10.9.2, *Adherence*, new number 6 added:

- 6.) Returned vaginal rings may serve as an additional indicator of product adherence.**

Appendix I, *Schedule of Study Visits and Evaluations, Laboratory, Pelvic* subheading:

	SCR	ENR	Monthly	Quarterly	Semi-Annual Visits	PUEV	Study Exit/ Term. Visit
Study VR adherence assessment(s)			*	*	*	*	

Edits have been made to Appendix V: *Sample Informed Consent Document (Enrollment)*, *You will be asked to use a study vaginal ring; as part of using this ring you will:* fourth bullet:

- Return your vaginal ring to study staff. **Study researchers may keep this ring and run additional tests on it. These tests will help researchers better understand your ring use.**

13. The following text has been added to the Screening and Enrollment Sample Informed Consent after the Research-Related Injury section to maintain compliance with the Food and Drug Administration (FDA) Final Rule to include trial registration information within the informed consent documents:

[Sites to insert where appropriate.] A description of this clinical trial will be available on <http://www.ClinicalTrials.gov>, as required by U.S. Law. This Web site will not include information that can identify you. At most, the Website will include a summary of the results. You can search this Web site at any time.

14. Edits have been made to Appendix V: *Sample Informed Consent Document (Enrollment)*, the *Consent for Off-Site Visits* section, second paragraph last sentence (these edits correct a typographical error in the text):

You can withdraw your consent for ~~the storage and future testing of specimens~~ **off-site visits** at any time by providing your request in writing to the person in charge of this study.

15. A typographical error has been corrected in Appendix V: *Sample Informed Consent Document (Enrollment)*, final signature block:

Sentence right before the signature block: If you have read this consent form, or had it read and explained to you, and you understand the information, and you voluntarily agree to ~~have the~~ **participate in this study**, please sign your name below.

The above information will be incorporated into the next version of the protocol at a later time if it is amended.

Clarification Memo #01 to:

MTN-020

A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring Containing Dapivirine for the Prevention of HIV-1 Infection in Women

DAIDS Document ID#: 11840

IND#: 108,743

Version 1.0 / 28 September 2011

Clarification Memo Date: 7 August 2013

Site Instruction and Implementation

The procedures clarified in this Clarification Memorandum (CM) have been approved by the NIAID Medical Officer and are to be implemented immediately upon issuance. IRB approval of this CM is not required by the sponsor; however, investigators may submit the CM to the IRB overseeing the study at their site for information. This CM is official MTN-020 documentation and is effective immediately. A copy of this CM must be retained in the study site's Essential Documents file for MTN-020. No change in informed consent is necessitated by or included in this CM.

Summary of Revisions

The purpose of this CM is to update the Protocol Team Roster, to clarify language in Section 7.7, *Behavioral Evaluations*, Section 9.5, *Genital Sexually Transmitted Infection, Reproductive Tract Infection and Other Clinical Findings*, and Section 13.6, *Participant Confidentiality*.

Except for modifications to the Protocol Team Roster, text to be deleted is noted by ~~strike through~~ and text to be added is noted below in **bold**.

Implementation

1. Contact information for the following individual has been updated in the Protocol Team Roster:

Added:

**Salim Abdool Karim, MB, ChB, PhD
CTU PI**

CAPRISA Private Bag X7 Congella
Durban, KwaZulu-Natal 4013
South Africa
Phone: 27-31-260-4548
Fax: 27-31-260-4549
Email: karims1@ukzn.ac.za

**Vaneshree Govender, MBBCh
Site Investigator**

MRC – HPRU
P.O. Box 70380
Overport, KwaZulu-Natal 4067 South
Africa
Phone: 27-31-242-3600
Fax: 27-31-242-3800
Email: vaneshree.govender@mrc.ac.za

**Phaleda Kumwenda
CWG Co-Representative**

University of North Carolina Project, Tidziwe
Centre, 100 Mzimba Rd, Kamuzu Central
Hospital, Private Bag A104, Lilongwe, Malawi
Phone: 265-1-750-610
Fax: 265-1-755-954
Email: pkumwenda@yahoo.co.uk

**Grace Chow, MS
Biologist**

Prevention Sciences Program
Division of AIDS
6700B Rockledge Drive, Rm. 5119
Bethesda, MD 20892-7628
Phone: 301-435-3747
Fax: 301-496-8530
Email: gchow@niaid.nih.gov

**Miriam Hartmann, MPH
Public Health Analyst**

RTI International
351 California Street, Suite 500
San Francisco, CA 94104 USA
Phone: 415-848-1385
Fax: 415-848-1377
Email: mhartmann@rti.org

**Thesla Palanee, PhD
Protocol Co-chair/Site Investigator**

WRHI - Research Centre
7 Esselen Street, Hillbrow
Johannesburg, 2038 South Africa
Phone: 27-11-358-5471
Fax: 27-86-554-1093
Email: tpalanee@whri.ac.za

**Mary Glenn Fowler, MD, MPH
CTU PI**

MU-JHU Research Collaboration
P.O. Box 23491
Kampala, Uganda
Phone: 256-414-532091
Fax: 256-41-4541044
Email: mgfowler@mujhu.org

**Nitesha Jeenaarain, B. Pharm
Site Investigator**

MRC – HPRU
P.O. Box 70380
Overport, KwaZulu-Natal 4067 South
Africa
Phone: 27-31-242-3600
Fax: 27-31-242-3800
Email: nitesha.jeenarain@mrc.ac.za

**Karen Patterson, MPH
MTN Program Manager**

FHCRC-SCHARP
1100 Fairview Ave. North, E3-315
PO Box 19024
Seattle, WA 98109-1024 USA
Phone: 206-667-7052
Fax: 206-667-4812
Email: karen@scharp.org

Ian Sanne, MD, FCP
CTU PI
Helen Joseph Hospital, Perth Road,
Westdene, Themba Lethu Clinic
Johannesburg, 2092 South Africa
Phone: 27-11-276-8800
Fax: 27-11 482 2130
Email: isanne@witshealth.co.za

Bukelwa Sontshatsha
CWG Co-Representative
No. 7 Mkhandlela Street, Old
Crossroads, 7455, Cape Town, South
Africa
Phone: 27-21-487-3010
Fax: 27-21-650-6963
Email: bsontshatsha@gmail.com

Robin Wood, MD
CTU PI
P.O. Box 13801, Mowbray
Cape Town 7705 South Africa
Phone: 27-21-650-6966
Fax: 27-21-650-6963
Email: robin.wood@hiv-research.org.za

Samantha Siva, MMed Sci
Site Investigator
MRC – HPRU
P.O. Box 70380
Overport, KwaZulu-Natal 4067 South Africa
Phone: 27-31-242-3600
Fax: 27-31-242-3800
Email: samantha.siva@mrc.ac.za

Taha Taha, MBBS, PhD
CTU PI
615 North Wolfe Street,
Room E-6011
Baltimore, MD, 21205 USA
Phone: 410-614-5255
Fax: 410-955-1836
Email: ttaha@jhsph.edu

Updated:

Nyaradzo Mgodzi, MBChB, MMed
Site Investigator
UZ-UCSF Collaborative Research
Programme
15 Phillips Avenue, Belgravia
Harare, Zimbabwe
Phone: 263-912-264-616
Fax: 263-4-704897
Email: nmmgodi@uz-ucsf.co.zw

Felix GS Mhlanga, MBChB, MMed
Site Investigator
UZ-UCSF Collaborative Research
Programme
15 Phillips Avenue, Belgravia
Harare, Zimbabwe
Phone: 263-912-335-232
Fax: 263-4-704-897
Email: fmhlanga@uz-ucsf.co.zw

Rachel Scheckter, MPH, IBCLC
Clinical Research Manager
FHI 360
P.O. Box 13950
Research Triangle Park, NC 27709 USA
Phone: 919-544-7040 Ext. 11392
Fax: 919-544-7261
Email: rscheckter@fhi360.org

Elizabeth Montgomery, MHS, PhD
BWRG Representative
RTI International
351 California Street, Suite 500
San Francisco, CA 94104 USA
Phone: 310-837-2772
Fax: 310-841-2772
Email: emontgomery@rti.org

Kat Richards, MPH
Clinical Research Manager
FHI 360
P.O. Box 13950
Research Triangle Park, NC 27709
USA
Phone: 919-544-7040 Ext. 11306
Fax: 919-544-7261
Email: krichards@fhi360.org

Ariane van der Straten, PhD, MPH
BRWG Representative
RTI International
351 California Street, Suite 500
San Francisco, CA 94104 USA
Phone: 415-848-1324
Fax: 415-848-1330
Email: ariane@rti.org

The following individuals have been removed from the Protocol Team Roster: Missy Cianciola, Nicola Coumi, Shayhana Ganesh, Vijayanand Guddera, Karen Isaacs, Marwah Jenneker, Newton Kumwenda, Tsitsi Magure, Modulakgotla Anthony Sebe, Yuktेशwar Sookrajh

2. Within Section 7.7, *Behavioral Evaluations, Sexual Activity, Condom Use and Intravaginal Practices* subsection, a clarifying statement has been added:

Note: Behavioral evaluations – which may include questions on sexual activity, condom use, and intravaginal practices – will be conducted quarterly, though the frequency of asking about each topic may vary. Behavioral evaluations will be tailored to each visit according to appropriate timing of the specific topic.

3. To maintain consistency with Section 6.7, *Use of Intravaginal Medications and Practices*, Section 9.5, *Genital Sexually Transmitted Infection, Reproductive Tract Infection and Other Clinical Findings*, the last sentence of the first paragraph has been updated:

Vaginally applied medications ~~should not be used~~ **will be discouraged**, except that vaginal azoles should be used to treat symptomatic candidiasis among pregnant women.

4. Section 13.6, *Participant Confidentiality*, the sixth sentence of the second paragraph has been edited to more closely align with the principles of ICH GCP 2.10 and 2.11:

[...] Forms, lists, logbooks, appointment books, and any other listings that link participants' identification numbers to identifying information will be stored in a ~~separate~~, locked file in an area with limited access. [...]

The above information will be incorporated into the next version of the protocol if it is amended.

Clarification Memo #02 to:

MTN-020

A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring Containing Dapivirine for the Prevention of HIV-1 Infection in Women

DAIDS Document ID#: 11840

IND#: 108,743

Version 1.0 / 28 September 2011

Clarification Memo Date: 12 November 2014

Site Instruction and Implementation

The procedures clarified in this Clarification Memorandum (CM) have been approved by the NIAID Medical Officer and are to be implemented immediately upon issuance. IRB approval of this CM is not required by the sponsor; however, investigators may submit the CM to the IRB overseeing the study at their site for information. This CM is official MTN-020 documentation and is effective immediately. A copy of this CM must be retained in the study site's Essential Documents file for MTN-020. No change in informed consent is necessitated by or included in this CM.

Summary of Revisions

The purpose of this CM to clarify protocol text that was previously modified in MTN-020 LoA #01 (issued on November 7, 2011) to ensure that the collection of plasma, as well as the completion of CD4+ T cell count and HIV-1 RNA PCR, continues for the duration of HIV-positive participants' follow-up.

Except for modifications to the Protocol Team Roster, text to be added is noted below in **bold**.

Implementation

1. The following Protocol Team Roster has been updated as follows:

Jennifer M. Berthiaume, MPH, MSW
Project Manager
FHCRC – SCHARP
1100 Fairview Ave. North, E3-314
P.O. Box 19024
Seattle, WA 98109-1024
Phone: 206-667-1230
Fax: 206-667-4812
Email: jberthia@scharp.org

Katie Doolan Schwartz, MPH
Senior Clinical Research Manager
FHI 360
359 Blackwell St., Ste. 200
Durham, NC 27701 USA
Phone: 919-544-7040 Ext.11425
Fax: 919-544-7261
Email: kschwartz@fhi360.org

Ashley Mayo, MPH
Clinical Research Manager
FHI 360
359 Blackwell St., Ste. 200
Durham, NC 27701 USA
Phone: 919-544-7040 Ext. 11164
Fax: 919-544-0904
Email: amayo@fhi360.org

Rachel Scheckter, MPH, IBCLC
Clinical Research Manager
FHI 360
359 Blackwell St., Ste. 200
Durham, NC 27701 USA
Phone: 919-544-7040 Ext. 11392
Fax: 919-544-7261
Email: rscheckter@fhi360.org

2. Section 7.5.1, *Participants Who Become Infected with HIV-1*, fourth paragraph, second bullet, has been updated to clarify the frequency of the collection of plasma as well as the completion of CD4+ T cell count and HIV-1 RNA PCR, in order to maintain consistency with MTN-020 LoA #01 issued on November 7, 2011.

- The 1st, 3rd, 6th, 12th, and 18th scheduled ASPIRE visit **and every 6 months** after the participant is informed of her HIV-infection.

The above information will be incorporated into the next version of the protocol if it is amended.

Microbicide Trials Network

CLARIFICATION MEMO #03 TO:

MTN-020

A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring Containing Dapivirine for the Prevention of HIV-1 Infection in Women

DAIDS Document ID#: 11840

IND#: 108,743

Version 1.0 / 28 September 2011

Clarification Memo Date: 17 March 2015

Section 1: Summary of Clarifications and Rationale

The procedures clarified in this Clarification Memorandum (CM) have been approved by the NIAID Medical Officer and are to be implemented immediately upon issuance. IRB approval of this CM is not required by the sponsor; however, investigators may submit the CM to the IRB overseeing the study at their site for information. This CM is official MTN-020 documentation and is effective immediately. A copy of this CM must be retained in each study site's Essential Documents file for MTN-020. No change in informed consent is necessitated by or included in this CM.

This CM clarifies the procedures to be performed at the Product Use End Visit (PUEV) when the PUEV coincides with a Semi-Annual Visit.

Section 2: Implementation

Text to be deleted is noted with a ~~strike through~~ and text to be added is in **bold**.

- 1.) The description attached to the semi-annual visit symbol under Table 6: *Follow-up Visits: Monthly, Quarterly, Semi-Annually* has been updated:
 - ▶ = to be completed at all semi-annual visits ~~only~~ (Months 6, 12, 18, etc.) **and at PUEV when the PUEV coincides with a semi-annual visit. Procedures related to the provision of study product will be omitted at PUEV.**
- 2.) To align with the clarification to Table 6: *Follow-up Visits: Monthly, Quarterly, Semi-Annually*; Appendix I: *Schedule of Study Visits and Procedures* a note has been added to the PUEV column:

	SCR	ENR	Monthly Visits	Quarterly Visits	Semi-Annual Visits**	PUEV**	Study Exit/Term. Visit
--	-----	-----	----------------	------------------	----------------------	--------	------------------------

****= When the PUEV coincides with the timing of a Semi-Annual Visit (Months 6, 12, 18, etc.), all procedures except for the provision of study product and related procedures will be conducted.**

The above information will be incorporated into the next version of the protocol at a later time if it is amended.

MTN-020 Statistical Analysis Plan

A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring Containing Dapivirine for the Prevention of HIV-1 Infection in Women

Microbicide Trials Network

Funding Agencies:

Division of AIDS, US National Institute of Allergy and Infectious Diseases

US National Institute of Mental Health

US National Institutes of Health

Grant #:

UM1 AI 068633-06

DAIDS Protocol #: 11840

IND Sponsor:

International Partnership for Microbicides

IND# 108,743

Protocol Statistician:

Elizabeth R. Brown, ScD

Version 1.0

September 3, 2015

APPROVAL SIGNATURE PAGE

MTN-020 Statistical Analysis Plan

A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring Containing Dapivirine for the Prevention of HIV-1 Infection in Women

I have read the above referenced Statistical Analysis Plan and approve its contents.

Elizabeth R. Brown, ScD
MTN-020 Protocol Statistician
Fred Hutchinson Cancer Research Center

September 3, 2015

Date

LIST OF ABBREVIATIONS AND ACRONYMS

ACASI	audio computer-assisted self-interview
AE	adverse event
AIDS	acquired immunodeficiency syndrome
ALT	alanine transaminase
ART	antiretroviral therapy
ARV	antiretroviral
ASPIRE	A Study to Prevent Infection with a Ring for Extended Use
AST	aspartate aminotransferase
BLQ	below limit of quantification
BV	bacterial vaginosis
CI	confidence interval
CRF	case report form
DAIDS	Division of AIDS, US National Institutes of Health
DPV	dapivirine
DSMB	Data and Safety Monitoring Board
EAE	expedited adverse event
FHCRC	Fred Hutchison Cancer Research Center
HIV	human immunodeficiency virus
HR	hazard ratio
ID	identification number
ITT	intent-to-treat
MedDRA	Medical Dictionary for Regulatory Activities
M-H	Mantel-Haenszel
m-ITT	modified intent-to-treat
MTN	Microbicide Trials Network
NL	network laboratory
p-y	person-years
PCR	polymerase chain reaction
PDL	plasma dapivirine levels
PH	proportional hazards
PK	pharmacokinetic(s)
PrEP	pre-exposure prophylaxis
PUEV	Product Use End Visit
PSRT	Protocol Safety Review Team
PTID	Participant Identification Number
RNA	ribonucleic acid
RR	relative risk
SAE	serious adverse event
SCHARP	Statistical Center for HIV/AIDS Research and Prevention
SDMC	Statistical Data Management Center
SEV	study exit visit
SOC	System Organ Class
STI	sexually transmitted infection
VR	vaginal ring
WB	Western blot

1	Table of Contents	
2	Study Objectives and Summary	6
3	General Design Considerations.....	7
3.1	Randomization	8
3.2	Blinding.....	8
4	General Statistical Considerations	9
4.1	Methods for Handling Missing and Inconsistent Data	10
4.2	Disposition of Trial Participants.....	10
5	Cohorts and Datasets for Primary and Complementary Analyses.....	11
6	Effectiveness Analyses for HIV-1 Infection.....	11
6.1	Primary Effectiveness Analysis	11
6.2	Pre-defined Stratified Analyses	12
6.3	Complementary Effectiveness Analyses	14
6.3.1	Product Adherence Analyses.....	14
6.3.2	Protocol Adherent Analysis	15
6.3.3	By-protocol Sensitivity Analysis	15
7	Primary Safety Analysis.....	16
8	Analysis of Secondary Endpoints	16
8.1	Adherence	16
8.2	Acceptability	16
8.3	HIV-1 Drug Resistance.....	17
9	Evaluation of Baseline Characteristics.....	17
9.1	Screening.....	17
9.2	Accrual.....	17
9.3	Demographics.....	17
9.4	Baseline Relationship and Sexual Risk Behaviors	17
9.5	Baseline Abnormal Pelvic Exam Findings	18
9.6	Baseline Sexually Transmitted Infections (STIs).....	18

9.7	Baseline Contraceptive Use	18
10	Reporting of Follow-up Characteristics.....	18
10.1	Visit and Study Retention	18
10.2	Study Termination.....	18
10.3	Self-reported Product Adherence	18
10.4	Acceptability	19
10.5	Product Holds	19
10.6	Pregnancy Incidence and Outcomes.....	19
10.7	Sexual Risk Behaviors.....	19
10.8	Social Impact.....	19
10.9	Safety Laboratory Results	19
10.10	Abnormal Pelvic Exam Findings	20
10.11	Adverse Experiences.....	20
10.12	Protocol Deviations	20
10.13	HIV-1 Incidence.....	20
11	References.....	20
	Appendix 1. MTN-020 Visit Windows.....	21

2 Study Objectives and Summary

This section summarizes the protocol and objectives covered in this Statistical Analysis Plan (SAP).

Protocol title: A Multi-Center, Randomized, Double-Blind, Placebo-Controlled Phase 3 Safety and Effectiveness Trial of a Vaginal Matrix Ring Containing Dapivirine for the Prevention of HIV-1 Infection in Women

Short Title:	A Study to Prevent Infection with a Ring for Extended Use (ASPIRE)
Clinical Phase:	Phase 3
IND Sponsor:	International Partnership for Microbicides
Protocol Chair:	Jared Baeten, MD, PhD
Protocol Co-chair:	Thesla Palanee, PhD
Sample Size:	2,629 women
Study Population:	Sexually active HIV-uninfected women, non-pregnant, 18-45 years of age
Study Sites:	Sites selected by the MTN Executive Committee
Study Design:	Multi-center, two-arm, randomized (1:1), double-blind, placebo-controlled Phase 3 trial
Study Duration:	<p>Accrual will require approximately 12 months. Each participant will engage in the screening process for up to 4 weeks (28 days) prior to enrollment and will use investigational product until 120 events (HIV-1 seroconversions) are observed in the trial. Based on the statistical assumptions listed below, the targeted number of incident seroconversions is expected to be reached approximately 12 months after the date upon which the last participant enrolls in the trial.</p> <p>Each participant will have 4 additional weeks of follow-up after ring discontinuation, to identify HIV-1 seroconversions that are not detected during the product-use period.</p>
Study Products:	<ul style="list-style-type: none">• Dapivirine Vaginal Ring (VR)• Placebo VR
Study Regimen:	Participants will be randomized in a 1:1 ratio to receive either a silicone elastomer vaginal matrix ring containing 25 mg of dapivirine or a placebo VR

Primary Objectives:

1. To determine the *effectiveness* of dapivirine (25 mg) administered in a silicone elastomer vaginal matrix ring, when inserted once every 4 weeks, in preventing HIV-1 infection among healthy sexually active HIV-uninfected women
2. To assess the *safety* of dapivirine (25 mg) administered in a silicone elastomer vaginal matrix ring, when inserted once every 4 weeks over the investigational product use period

Primary Endpoints:

- **Effectiveness**
 - HIV-1 infection as measured by seroconversion at the end of the investigational product use period with seroconversion defined by the algorithm in Appendix III of the MTN-020 Version 1.0 protocol
- **Safety**
 - Grade 2 adverse events (AEs) judged to be related to study product
 - Grade 3 and 4 AEs
 - All serious adverse events

Secondary Objectives:

1. To evaluate the *acceptability* of the study VR (dapivirine or placebo) in HIV-uninfected women, when inserted once every 4 weeks over the investigational product use period
2. To evaluate the *adherence* to the study VR (dapivirine or placebo) in HIV-uninfected women, when inserted once every 4 weeks over the investigational product use period
3. To assess the frequency of HIV-1 *drug resistance* in women who acquire HIV-1 infection while using the investigational product
4. To evaluate the *relationship between drug concentration and HIV-1 seroconversion*

Secondary Endpoints:

Acceptability

- Participant report of participant and partner-related acceptability including (dis)comfort, ring insertion and removal/expulsion issues, change in sexual feelings, willingness to use in the future

Adherence

- In the protocol, the adherence endpoint was defined as frequency of study VR removal/expulsions (voluntary and involuntary) and duration without VR inserted in vagina. Since the time the protocol was written, a comprehensive adherence monitoring program was instituted based on objective biologic measures of adherence. These biomarkers will now serve as adherence endpoints. Self-reported measures will be summarized separately.

HIV-1 Drug Resistance

- HIV-1 drug resistance mutations among participants who acquire HIV-1 infection

Drug Concentration Data

- Steady-state drug concentrations in blood. The protocol originally included vaginal fluid concentrations; however, these assays have been postponed for MTN-020.

3 General Design Considerations

MTN-020 is a multi-site, two-arm, double-blind, randomized, placebo-controlled phase III clinical trial to evaluate the safety and effectiveness of dapivirine (25 mg) in a silicone elastomer vaginal matrix ring, inserted once every 4 weeks for the prevention of HIV-1 infection in healthy, sexually active HIV-1-uninfected women, when compared to a placebo vaginal ring. The study enrolled women from fifteen study sites in four African countries: Malawi (Blantyre, Lilongwe),

Uganda (Kampala), South Africa [Cape Town, Durban (7 sites), Johannesburg] and Zimbabwe [Chitungwiza (2 sites), Harare]. The first study site was activated on July 19, 2012, the first enrollment occurred on August 21, 2012 and last enrollment occurred on June 12, 2014. A total of 5,516 participants were screened and 2,629 were enrolled. Study follow-up will end in June 2015.

MTN-020/ASPIRE study consists of a screening visit, enrollment visit and monthly follow-up visits where the vaginal ring is inserted at the clinical site before the participant completes the visit. Follow-up will continue until 165 HIV-1 infection endpoints are observed (thus, is an endpoint-driven study) and participants enrolled early on in the study may have up to or more than 24 follow-up visits. Follow-up visits consist of data collection for behavioral, clinical, laboratory, pelvic exams and dispensation/collection of study product. At each monthly visit participants are asked (or assisted) to remove the previous month's vaginal ring that is then replaced by a new ring. Study procedures are completed at monthly, quarterly, semi-annual, product use end and termination visits.

3.1 Randomization

The randomization scheme/lists were generated and maintained by the Statistical Center for HIV/AIDS Research and Prevention (SCHARP), the MTN Statistical and Data Management Center (SDMC). Participants were assigned at random to one of the two arms in a 1:1 ratio. The randomization lists were stratified by site using block sizes of 12. Six unique character codes using the letters G, H, I, J, K, L and twenty-five unique 3-digit numeric codes per letter code were used to blind the identity of the MTN-020 study gel products, and to accommodate additional lots of product throughout the study. The character codes are referred to as product bin codes and the numeric codes are referred to as sub-lot codes. Prior to site activation, SCHARP provided each clinical site with a binder containing a set of two-part NCR (no carbon required) prescriptions with sequential randomization numbers ranging from 001-996 per site. Each prescription was pre-printed with the CRS Name, CRS Location, DAIDS Site ID, and a randomization number. The site clinics were instructed to assign the prescriptions in sequential (ascending) randomization number order. Once completed, the top white sheet (original) labeled "Pharmacy" was to be submitted to the pharmacy, and the bottom yellow copy (duplicate) labeled "Clinic" was to be stored in the participant's study notebook.

Once pharmacy staff received a completed MTN-020 prescription, they were to obtain the MTN-020 Participant-Specific Pharmacy Dispensing Record with the same randomization number as printed on the prescription. The SDMC provided the Participant-Specific Dispensing Records to each site pharmacy. These were two-sided documents with the CRS Name, CRS Location, DAIDS Site ID, and randomization number pre-printed on both sides. Also pre-printed on the dispensing records were the corresponding bin codes and sub-lot codes assigned according to the randomization number. This information was pre-printed on the top of all pages of the Participant-Specific Dispensing Record.

Once a ring was obtained for dispensing, pharmacy staff was to check that the sub-lot code printed on the tear-off portion of the ring over-wrap label matched one of the sub-lot codes printed on the dispensing record for that participant and randomization number. Once that was verified, pharmacy staff were to place the tear-off portion of the ring over-wrap label in the designated cell on the dispensing record, and complete the Date Dispensed, Bin Code Dispensed, Sub-lot Code Dispensed, and Dispensing Staff Initials fields. The appropriate randomization number assigned to the participant was also to be recorded on the Enrollment CRF in item 6 at the time of randomization.

3.2 Blinding

Study staff and participants were blinded to the treatment arm assignments. Randomization documentation and pharmacy dispensing records were stored in a secure location at the site

pharmacies apart from the participant clinic file. Therefore, randomization information was not accessible to study staff members.

Blinding of the randomization arm assignments to study staff and participants will be maintained until the study database is closed (i.e., all data is cleaned and verified via data quality checks), the final analyses outlined in this SAP have been completed, and the MTN-020 Study Team and DAIDS officer have given sign-off to proceed with unblinding the study participants.

4 General Statistical Considerations

Descriptive statistics that will be used to summarize continuous variables are as follows: mean and standard deviation, median and interquartile range, quartiles, range, and number of missing data values. If applicable, continuous data that are skewed will be transformed to meet assumptions of normality. For categorical variables, descriptive statistics that will be used include the following: frequencies, relative frequencies, and the number of missing data values.

Descriptive analyses summarizing baseline and follow-up data will be stratified by site and/or country, and treatment arm separately. Line, scatter and box plots will be used, as appropriate, for longitudinal data representations. The document entitled Examples of Tables, Listings and Figures for the MTN-020 Statistical Analysis Plan shows mock representations of the descriptive analyses.

A baseline measure is defined as either data collected at the Screening Visit (the visit window opens 28 days prior to the Enrollment visit and the visit code = 97.0 = 9701) or at the Enrollment Visit (visit code = 98.0 = 9801). If the same data is collected at the Screening Visit and the Enrollment Visit, then data collected at the Enrollment Visit will be used. See Appendix 1 for details regarding the MTN-020 visit windows.

Data from both regularly scheduled and unscheduled (referred to as interim) visits will be used in the analyses, as appropriate. Unless otherwise noted, when a participant was unable to complete a regularly scheduled visit and her visit procedures were completed at an interim visit within the respective visit window, the interim visit data will be used. Regularly scheduled and interim visits are distinguishable in the database by the third digit in the visit code. For example, 98.0 = 9801 is the regularly scheduled enrollment visit code, 98.1 = 9811 is the first interim visit post enrollment up to the window open date of the Month 1 visit (i.e., up to and including 13 days post enrollment), 98.2 = 9821 is the second interim visit post enrollment up to the window open date of the Month 1 visit, 20.0 = 2001 is the regularly scheduled Month 20 visit code, 20.1 = 2011 is the first interim visit after the regularly scheduled Month 20 visit up to the window open date of the Month 21 visit (i.e., up to and including 573 days post enrollment), 20.2 = 2021 is the second interim visit after the regularly scheduled Month 20 visit up to the window open date of the Month 21 visit, and so on.

Since MTN-020/ASPIRE is a randomized trial, it is anticipated that the treatment arms will be comparable at baseline with respect to demographic, clinical, and behavioral characteristics. For this reason, no baseline adjustments are planned prospectively; however, the data will be reviewed to assess any potentially relevant baseline imbalances.

Subgroup analyses will be performed on the primary HIV-1 effectiveness endpoint using the following baseline stratification variables: age, country, educational status, marital status, STIs at baseline, partner knowledge of ring use, and number of sex partners in the last 3 months. Subgroup analyses will be completed on the Primary Effectiveness Cohort, Primary Effectiveness Dataset that includes all 15 sites' data as well as on the Complementary Adherent Subset Effectiveness Cohort, Complementary Adherent Subset Effectiveness Dataset that includes data from the following 13 sites only: Blantyre, Lilongwe, Cape Town, eThekweni, Botha's Hill, Chatsworth, Verulam, Umkomaas, WRHI, Kampala, Seke South, Spilhaus and Zengeza.

Statistical analyses outlined in this SAP will be conducted by the MTN SDMC using SAS® for Linux/Unix (Version 9.2 or higher, SAS Institute Inc., Cary, North Carolina, USA) or R (R Foundation for Statistical Computing, Vienna, Austria).

4.1 Methods for Handling Missing and Inconsistent Data

Although MTN-020 study procedures are in place to minimize the amount of missing values for primary and secondary endpoints, it is likely that missing data will occur. If specific analyses require rules for missing data, those will be specified in the statistical plan specific to that analysis.

4.2 Disposition of Trial Participants

The disposition of trial participants will be presented in a CONSORT diagram and table. The measure, statistic and data source used to define each variable are described in the table below.

Measure	Statistic	Data Source
Participants screened	Number and percentage	Participant ID is not missing and “Does this participant meet all eligibility criteria?” (Q1) is not missing Source: Eligibility Criteria CRF
Participants eligible and not eligible	Number and percentage	“Does this participant meet all eligibility criteria?” (Q1) is ‘yes’ Source: Eligibility Criteria CRF
Participants not eligible	Number and percentage	“Does this participant meet all eligibility criteria?” (Q1) is ‘no’ Source: Eligibility Criteria CRF
Participants randomized into the study	Number and percentage	Randomization number assigned is not missing (Q6) and date prescription assigned is not missing (Q7) Source: Enrollment CRF
Participants who were inappropriately enrolled	Number and percentage	Reason for termination (Q2) equals ‘inappropriate enrollment’ (2i) Source: Termination CRF
Participants who completed the study	Number and percentage	Reason for termination (Q2) equals ‘scheduled exit visit/end of study’ (2a) Source: Termination CRF
Reasons participants terminated early from the study	Number and percentage	Reason for termination (Q2) equals 2b, 2c, 2e, 2f, 2g, or 2k Source: Termination CRF
Other reasons for termination	Number and percentage	Reason for termination (Q2) equals 2j or 2l Source: Termination CRF
Participants permanently discontinued from study product use	Number and Percentage	Participant ID is not missing, subsumed box is not checked, and response to “Was the participant instructed to resume study product use?” (Q4) equals ‘no-permanently discontinued’ Source: Product Hold CRF
Reasons for permanent discontinuation of study product	Number and Percentage	Responses to “Why is study product being held?” (Q2) among participants identified as permanently discontinued from study product use Source: Product Hold CRF

5 Cohorts and Datasets for Primary and Complementary Analyses

This section describes the cohorts and corresponding datasets for the primary safety and effectiveness analyses. In addition, we will perform a set of analyses designed to complement the primary analysis that we define as the Complementary Effectiveness Analyses. In the definitions below, cohort refers to the study participants included in a dataset; whereas the datasets further specify which visits are included from the specified cohort.

Primary Safety Cohort: The Primary Safety Cohort includes all eligible, randomized participants. Eligible, randomized participants are defined as per Section 4.2. All participants will be analyzed as members of the treatment arm to which they were randomized regardless of adherence to the planned course of treatment.

Intent-to-treat (ITT) Safety Dataset: Includes all participants in the Primary Safety Cohort. Participants' data will be included from all participant-visits after the Enrollment Visit up to and including the Study Exit Visit (SEV). This dataset includes the planned four weeks of follow-up time whereby participants are off-product between the Product Use End Visit (PUEV) and the SEV.

Primary Effectiveness Cohort: The primary effectiveness analyses will be conducted on the Primary Effectiveness Cohort, a modified intent-to-treat (m-ITT) cohort that differs from the Primary Safety Cohort only in the exclusion of participants deemed to be HIV-1 RNA positive at the time of randomization.

Primary Effectiveness Dataset: Includes all post-randomization follow-up time (i.e., after the Enrollment Visit) from the Primary Effectiveness Cohort until HIV-1 seroconversion or end of study follow-up, whichever occurs first.

Primary Effectiveness Sensitivity Dataset: Includes all post-randomization follow-up time (i.e., after the Enrollment Visit) from the Primary Effectiveness Cohort until HIV-1 seroconversion or end of study follow-up defined as the last negative HIV-1 rapid test date at the PUEV, whichever occurs first. This dataset differs from the Primary Effectiveness Dataset in that it does not include the person-years of follow-up during the planned four weeks off product at the end of the study up to and including the SEV.

Complementary Adherent Subset Effectiveness Cohort: A complementary effectiveness analysis will be conducted on a pre-defined subset of the Primary Effectiveness Cohort, including 13 sites whose early performance metrics were determined to achieve an acceptable level.

Complementary Adherent Subset Effectiveness Dataset: Includes all post-randomization follow-up time from the Complementary Adherent Subset Effectiveness Cohort until HIV-1 seroconversion or end of study follow-up, whichever occurs first. The 13 sites included are as follows: Blantyre, Botha's Hill, Cape Town, Chatsworth, eThekweni, Kampala, Lilongwe, Seke South, Spilhaus, Umkomaas, Verulam, WRHI, and Zengeza.

6 Effectiveness Analyses for HIV-1 Infection

6.1 Primary Effectiveness Analysis

Objective: To determine the *effectiveness* of dapivirine (25 mg) administered in a silicone elastomer vaginal matrix ring, when inserted once every 4 weeks, in preventing HIV-1 infection among healthy sexually active HIV-uninfected women

Endpoint: HIV-1 seroconversion

Exposure: Treatment arm assignment

Cohort: Primary Effectiveness Cohort

Dataset: Primary Effectiveness Dataset

Definition of the Primary HIV-1 Endpoint: To harmonize with IPM-027, the definition of the primary endpoint in this MTN-020 SAP Version 1.0 differs slightly from that in Section 10 of the MTN-020 Version 1.0 protocol. In the protocol, HIV-1 seroconversions occurring after the PUEV were not considered endpoints. In this SAP, however, they are considered endpoints if the participant has a positive RNA PCR at the PUEV (note that the protocol definition of the endpoint will be analyzed in a sensitivity analysis as detailed in Section 6.3.3).

Details of the primary HIV-1 endpoint are as follows: HIV-1 infection as measured by seroconversion was assessed monthly to determine the primary endpoint. All study sites performed HIV-1 testing per the algorithm in Appendix III of the MTN-020 Version 1.0 protocol for purposes of primary endpoint determination. In addition, the MTN Network Lab (NL) verified the results of HIV-1 testing performed at the study site laboratories for purposes of eligibility determination and primary endpoint confirmation as specified in the protocol. In addition, an Endpoint Adjudication Committee (EAC) provided guidance on endpoint determination to the Protocol Team on an as-needed basis. See the MTN Manual of Operational Procedures (MOP) for detailed information on the composition, roles, and responsibilities of the EAC (www.mtnstopshiv.org).

The primary HIV-1 seroconversion endpoint is defined as the time of first detection of HIV-1 antibodies if this occurs at or before the PUEV visit. If HIV-1 antibodies are detected at the SEV and further testing results in a positive RNA PCR at PUEV, the participant will be treated as seroconverting at the time of the PUEV. If the participant does not HIV-1 seroconvert, her seroconversion time will be censored at the last negative HIV-1 test date at or before the scheduled PUEV. All participants who test positive for HIV-2 will have their HIV-1 seroconversion time censored at the date of the test that determined HIV-2 seroconversion. In some cases where the algorithm results in an unclear endpoint determination, the EAC's determination of whether it is an endpoint and/or the timing of the endpoint will be used as a participant's final primary endpoint result.

Analysis Details: A Cox Proportional Hazards (PH) model stratified by site will be used to assess the effectiveness of the dapivirine vaginal ring compared to the placebo ring (i.e., treatment arm assignments) on the m-ITT cohort. Product effectiveness will be expressed as a percent reduction in the HIV-1 incidence rate (i.e., $100 \times [1 - (\text{active product HIV-1 infection rate}/\text{corresponding placebo HIV-1 infection rate})]$). To aid understanding of the results from the Cox PH model cumulative incidence analysis, Kaplan-Meier curves of time to HIV-1 seroconversion will be presented by site and treatment arm. In addition, we will evaluate Schoenfeld residuals, a plot of $\log(-\log(\text{survival}))$ versus \log of survival time and the LOWESS smooth for visual inspection of the proportional hazards assumption. In the event that visual inspection indicates severe violations of the proportional hazards assumption, more appropriate models will be explored (e.g., time-by-treatment interactions in a Cox PH model).

6.2 Pre-defined Stratified Analyses

The Primary Effectiveness Analysis will be repeated in strata defined by baseline characteristics as follows:

1. Age (< 25 vs. \geq 25 years old)
2. Country (South African sites vs. Non-South African sites)
3. Educational status (less than secondary school vs. secondary school or higher)
4. Marital status (married vs. non-married)
5. Baseline STI (a positive result for any of the following: chlamydia, gonorrhea, trichomoniasis, or syphilis vs. all negative results)
6. Partner knowledge of ring use (primary partner knows participant is using vaginal ring vs. primary partner does not know/unsure)
7. Number of sex partners in the last 3 months (0-1 vs. 2+)

The measure, description and definition and/or data source used to define each stratum are described in the table below.

Measure	Description	Definition and/or Data Source
Age	Indicator variable for age in years categorized as < 25 and >= 25	Age calculated as INT ((date of enrollment – date of birth) / 365.25 or if date of birth unknown then age in years (Q1) Source: Demographics CRF
Country	Indicator variable for South African sites vs. non-South Africa sites	Site is defined by the first three digits of the participant ID and country is defined by the site. South African sites are as follows: Botha’s Hill, Cape Town, Chatsworth, eThekwini, Isipingo, Tongaat, Umkomaas, Verulam, and WRHI. Non-South African sites are as follows: Blantyre, Kampala, Lilongwe, Spilhaus, Seke South, Zengeza Source: Participant ID
Educational Status	Indicator variable for less than secondary school vs. secondary school or higher	Highest level of education (Q3) Source: Demographics CRF
Marital Status	Indicator variable for married vs. non-married	“Is the participant currently married?” (yes/no) (Q2) Source: Demographics CRF
Baseline STI	Indicator variable for whether a positive result was observed at screening for any of chlamydia, gonorrhea, trichomoniasis, or syphilis versus negative results for all STIs	C. trachomatis (negative/positive) (Q4), N. gonorrhea (negative/positive) (Q3), Trichomonas Rapid Test (negative/positive) (Q2) Source: Screening STI Test Results CRF Syphilis screening test (non-reactive/reactive) (Q3a) and syphilis confirmatory test (negative/positive/indeterminate) (Q3b) Syphilis positive result = reactive on screening test and positive on confirmatory test; negative result = non-reactive on screening test or reactive on screening test and negative on confirmatory test; indeterminate confirmatory test results will be assessed and treated as a separate group, if appropriate. Source: Screening Specimen Storage CRF
Partner knowledge of ring use	Indicator variable for primary partner knows that the participant is using vaginal ring (yes) vs. primary partner does not know that participant is using vaginal ring (no)	“At any time in the past 3 months, have you had a primary sex partner?” (yes/no) (Q1) “Does he know you have been asked to use a vaginal ring as part of this study?” (yes/no/not sure) (Q4). If ‘yes’ to Q1 and ‘yes’ to Q4 then ‘yes’, otherwise ‘no’. Source: Baseline Behavior Assessment CRF
Number of sex partners in the last 3 months	Indicator variable for 0-1 partners vs. 2 or more partners	“How many sex partners other than a primary sex partner have you had in the past 3 months?”

Measure	Description	Definition and/or Data Source
		Source: Baseline Behavior Assessment CRF

In each case, differential effectiveness will be assessed through the inclusion of an interaction term between the baseline characteristic and the treatment arm assignment. In addition, incidence will be calculated by treatment arm within each stratum. The covariate for the interaction will be tested using a Wald test to assess for differential effectiveness.

6.3 Complementary Effectiveness Analyses

In complementary analyses, we will explore the effectiveness of the dapivirine vaginal ring compared to the placebo ring using statistically valid approaches to incorporate information about non-compliance to the protocol as well as the intervention. Below we describe four analyses designed to support the primary effectiveness analysis.

6.3.1 Product Adherence Analyses

We propose two analyses to assist in understanding the effectiveness of the dapivirine vaginal ring when used as instructed. The first replicates the primary analysis in the Complementary Adherent Subset Effectiveness Cohort. The second incorporates plasma dapivirine levels as a marker of product use within the Primary Effectiveness Cohort. The main product adherence analysis will be the Adherent Subset Analysis, however.

6.3.1.1 Product Adherence Analysis 1: Adherent Subset Analysis

Objective: For this analysis, the same analytical approach as described for the Primary Effectiveness Analysis will be applied to the Complementary Adherent Subset Effectiveness Cohort. Recognizing that early site metrics may not have adequately captured poor performance at sites, an exploratory analysis will also be conducted further excluding sites with overall performance metrics comparable to the excluded sites.

Endpoint: HIV-1 seroconversion

Exposure: Treatment arm assignment

Cohort: Complementary Adherent Subset Effectiveness Cohort

Dataset: Complementary Adherent Subset Effectiveness Dataset

Analysis Details: The Primary Effectiveness Analysis will be repeated on the Complementary Adherent Subset Effectiveness Dataset.

6.3.1.2 Product Adherence Analysis 2: Time-varying Adherence Analysis

Objective: Because of the low adherence in the MTN-003/VOICE study, the MTN-020/ASPIRE study team moved early to assess adherence objectively for participants enrolled in MTN-020/ASPIRE. As a result, we expect to have assessments of dapivirine levels in plasma available for most quarterly visits for all active treatment arm participants. Thus, we plan to perform time-varying analyses to correlate plasma drug levels to risk of HIV-1 seroconversion. This will also serve as the analysis for the Drug Concentration Secondary Endpoint.

Endpoint: HIV-1 seroconversion

Exposure: Time-varying indicator of product use (adherence)

Additional baseline covariates: participant age, marital status, number of male sex partners, presence of genital symptoms/STIs at baseline

Cohort: Primary Effectiveness Cohort

Dataset: Primary Effectiveness Dataset

Definition of exposure: The time-varying indicator of active product use (adherence) will be based on dapivirine plasma concentrations, categorized as being either adherent (> 95 pg/mL), or non-adherent (≤ 95 pg/mL). By default, placebo arm participants will be treated as unexposed throughout follow-up. Otherwise, adherence throughout a quarter will be defined as having a detectable dapivirine concentration at the end of the quarterly visit.

Analytical Approach: A time-varying Cox PH model will be developed with adherence as a time-varying exposure, and HIV-1 seroconversion as the outcome with censoring at the time of last negative HIV-1 test for those who do not seroconvert. Adherence at missed quarterly visits will be imputed using the Last Value Carried Forward approach. There will likely be participants who HIV-1 seroconvert before having adherence evaluated. We will use sensitivity analyses to estimate the impact on the analysis if these participants were adherent or non-adherent prior to seroconversion. Censoring rules will follow those in the Primary Effectiveness Analysis. Because adherence to the intervention is not randomized, we will need to adjust for relevant confounders for active treatment arm participants. Potential confounders will include participant age, marital status, number of male sex partners (categorized as 0, 1, 2 and 3+) and presence of genital symptoms/STIs at baseline.

6.3.2 Protocol Adherent Analysis

Objective: To assess the effectiveness of the dapivirine vaginal ring when participants are protocol compliant.

Endpoint: HIV-1 seroconversion

Exposure: Treatment arm assignment

Additional baseline covariates: participant age, marital status, number of male sex partners, presence of genital symptoms/STIs at baseline

Cohort: Primary Effectiveness Cohort

Dataset: Primary Effectiveness Dataset

Analysis Details: This analysis differs from the Primary Effectiveness Analysis only in the determination of censoring and exclusion of participants who were deemed to be inappropriately enrolled. Time to HIV-1 seroconversion will be censored to mimic follow-up time as if it were accrued under perfect protocol adherence as follows:

Censor at last negative test before detection of pregnancy or the first occurrence of three or more non-compliance events in a 12 month period, where a non-compliance event is defined as follows:

1. A missed visit
2. Participants reporting the ring is out for more than 12 hours
3. Participant fails to return product

Inappropriately enrolled participants will also be excluded from this analysis.

6.3.3 By-protocol Sensitivity Analysis

Objective: To implement the primary effectiveness analysis with the original endpoint definition from the protocol.

Endpoint: HIV-1 seroconversion

Exposure: Treatment arm assignment

Cohort: Primary Effectiveness Cohort

Dataset: Primary Effectiveness Sensitivity Dataset

Analysis Details: The Primary Effectiveness Analysis will be repeated using the endpoint as originally defined in the protocol. In this analysis, the endpoint will be time to HIV-1 seroconversion if seroconversion is detected at or before the PUEV. Seroconversions occurring after PUEV will not be counted. For participants who do not reach the endpoint described here, their follow-up time will be censored at the last negative HIV-1 rapid test at or before the scheduled PUEV.

7 Primary Safety Analysis

Objective: To assess the *safety* of dapivirine (25 mg) administered in a silicone elastomer vaginal matrix ring, when inserted once every 4 weeks over the investigational product use period.

Cohort: Primary Safety Cohort

Dataset: Intent-to-treat Safety Dataset

Outcomes:

- Grade 2 adverse events (AEs) judged to be related to study product
- Grade 3 and 4 AEs
- All serious adverse events

Analysis Details: The analysis of adverse events (AEs) will be mainly descriptive in nature. The number and percentage of participants experiencing adverse events will be presented per body system and preferred term, and by treatment arm.

For the most frequent AEs (i.e. AEs present in at least 5% of the subjects overall) the prevalence difference for dapivirine arm vs. placebo arm and its 95% confidence interval will be presented. The confidence interval will be determined based on linear regression with robust standard errors and an adjustment for site. Additionally, an AE dot plot will graphically display the prevalence by arm and corresponding prevalence differences with 95% confidence intervals (see the Examples of Tables, Listings and Figures for the MTN-020 Statistical Analysis Plan document for details). For clarity, prevalence difference is defined as the difference in the proportion of participants in the active and placebo arms experiencing the AE being analyzed. Separate tabulations will be created for AEs of special interest i.e. urogenital disorders and STIs.

8 Analysis of Secondary Endpoints

8.1 Adherence

The primary outcomes for the adherence analysis will be determined by plasma dapivirine levels (PDL) with cut-offs of below limit of quantification (BLQ), $BLQ < PDL \leq 95 \text{ pg/mL}$ and $PDL > 95 \text{ pg/mL}$. The primary adherence analysis will report the proportion adherent in each category over time and by site. Additional self-reported measures of product adherence will be summarized by site and treatment arm as described in Section 10.3.

8.2 Acceptability

The proportion of participants that respond positively (i.e., “likely” or “very likely”) to the question: “If in the future a vaginal ring was available that provided some protection against HIV, and it was similar to the one you used in this study, how likely would you be to keep it inserted in your vagina every day?” at any post-enrollment visit (from the Final/PUEV ACASI questionnaire administered at early termination, PUEV or when product is discontinued) among all eligible, randomized participants will be calculated along with a 95% confidence interval. A participant will be classified as having found the vaginal ring acceptable if she responds positively to the above question about willingness to use the ring if in the future it is found to provide protection against HIV. The difference in the proportion of participants who found the ring acceptable

between the dapivirine arm vs. placebo arm and the corresponding 95% confidence interval will be calculated.

8.3 HIV-1 Drug Resistance

A summary table will be presented that shows the number of participants with a completed resistance test, a successful resistance test, a failed resistance test and an NNRTI resistant strain by treatment arm. In addition, a line listing will be made that shows the dapivirine concentration in plasma, HIV-1 viral load and the NNRTI mutation (if applicable) among participants with a successful resistance test. Rates of drug resistance in women who HIV-1 seroconvert during the study will also be estimated and compared across treatment arms. Fisher's Exact test will be used to compare rates of drug resistance between the arms at HIV-1 seroconversion.

9 Evaluation of Baseline Characteristics

Unless otherwise specified, baseline characteristics will be summarized descriptively using appropriate summary statistics and reported across strata as described in Section 4. No formal statistical testing will be performed. The total number of eligible, randomized participants will be used as the denominator for all descriptive analyses pertaining to enrolled participants. See the Examples of Tables, Listings and Figures for the MTN-020 Statistical Analysis Plan document for further details of the proposed descriptive analyses outlined below.

9.1 Screening

The number of participants screened, enrolled and the reasons for why participants were not enrolled (including reasons for ineligibility) will be summarized in a table.

9.2 Accrual

The activation dates, first and last enrollment dates, enrollment targets, duration of accrual, screen to enroll ratio, average enrolled per month, percent enrolled, calendar month of accrual will be summarized in tables. In addition, plots showing accrual numbers over calendar month will be presented.

9.3 Demographics

Baseline demographics (from items 1-9a on the Demographics CRF) will include the following: participant age (calculated as $INT((\text{date of enrollment} - \text{date of birth}) / 365.25)$ or if date of birth unknown then age in years), marital status (married/not married), highest level of education [no schooling, primary school (partial and complete), secondary school (partial and complete), attended college or university], number of alcoholic drinks per week, number of cigarettes per day, ownership of cell phone (yes/no), if so, does she have her phone with her (yes/no), how long did it take the participant to travel from home to the clinic today (less than 30 minutes, 30-60 minutes, 1-2 hours, greater than 2 hours), does the participant earn income on her own (yes/no), and how does she earn income (formal employment, self-employment, and other).

9.4 Baseline Relationship and Sexual Risk Behaviors

Baseline relationship and sexual risk behaviors (from items 1-16 on the Baseline Behavioral Assessment) will include the following: had a primary sex partner in the past 3 months (yes/no), vaginal sex with primary partner in the past 3 months (yes/no), primary sex partner knows of participation in the trial (yes, no, not sure), primary sex partner knows participant has been asked to use ring (yes, no, not sure), primary sex partner is circumcised (yes, no, don't know), primary sex partner HIV status (HIV positive, HIV negative, participant does not know), primary sex partner is taking ARVs (yes, no, don't know), in the past month did primary sex partner come to the study clinic (yes/no), if primary partner came to the study clinic, did he come with the participant (yes/no), did he receive counseling or other services from the study clinic (yes/no), did he come to the study clinic for any other reason (yes, no, specify), have you had the same primary

sex partner for the last 3 months (yes/no), how many sex partners other than a primary sex partner have you had in the past 3 months, in the past 3 months, how many time in total have you had vaginal sex, how many acts of vaginal sex did you have in the past 7 days, how many acts of vaginal sex in the past 7 days were a male or female condom used, during the last act of vaginal sex that you had, was a male and/or female condom used (male condom, female condom, both, neither), in the past 3 months, how many times have you had anal sex, and during the last act of anal sex that you had was a male condom used (yes/no).

9.5 Baseline Abnormal Pelvic Exam Findings

Baseline abnormal pelvic exam findings will include the occurrence of findings shown on the Screening Pelvic Exam CRF.

9.6 Baseline Sexually Transmitted Infections (STIs)

Baseline sexually transmitted infections will include findings from the Screening STI Test Results CRF as follows: *Trichomonas vaginalis*, *Neisseria gonorrhoea*, Chlamydia, trachomatis, Syphilis and candida (buds and/or hyphae). The Syphilis result will be based on a reactive result to the Syphilis screening test plus a positive confirmatory test result.

9.7 Baseline Contraceptive Use

Baseline contraceptive use will include all methods in item 1 from the Baseline Family Planning CRF as follows: none, spermicide, diaphragm, sponge, intrauterine device (IUD), oral contraceptives/birth control pills (OCP), injectable contraceptives (e.g. Depo-Provera), Ortho Evra (The Patch), implants, male and female condoms, natural methods, sterilization, partner has a vasectomy and other (specify).

10 Reporting of Follow-up Characteristics

Unless otherwise specified, follow-up characteristics will be summarized descriptively using appropriate summary statistics and reported across strata as described in Section 4. No formal statistical testing will be performed. The total number of eligible, randomized participants will be used as the denominator for all descriptive analyses pertaining to enrolled participants. See the Examples of Tables, Listings and Figures for the MTN-020 Statistical Analysis Plan document for further details of the proposed descriptive analyses outlined below.

10.1 Visit and Study Retention

Visit retention will include the number and proportion of women who were expected, not expected, completed, not completed and missed and if missed, who terminated early by study visit. A plot showing retention by study month will be presented.

In addition, study retention based on completion of the HIV-1 primary endpoint determination will also be calculated. If a participant missed a visit but came back for a study visit at a later time, she will be considered to have been retained at any visits prior to the last visit that the HIV-1 primary endpoint was determined.

10.2 Study Termination

The reasons for study termination based on the Termination CRF will be presented in a table.

10.3 Self-reported Product Adherence

Data from the Ring Adherence CRF will be summarized as follows: number of participant-visits with access to a vaginal ring during the past month, participant-months where the ring was never out, participant-months where the ring was out for more than 12 hours continuously, longest number of days in a row the vaginal ring was out, reasons the ring was removed by participant or clinician, reasons ring came out on its own, and other reasons ring was removed by participant or

clinician. In addition, data from the Ring Collection/Insertion CRF will be summarized as follows: participant-visits with the Ring Collection/Insertion form, participant-visit used for the ring collection/insertion assessment, participant-visits where the ring was in place at start of visit, participant-visits where ring was not in place at start of visit, number of days the ring was out prior to visit, number of new rings dispensed to participant (none, 1, 2, 3), if none, reasons for why ring was not dispensed (participant on clinical hold or discontinuation, participant declined study ring, scheduled PUEV, early termination, other, missing), was a new ring inserted at this visit (yes/no), reason ring was not in place at end of visit (participant declined to have ring inserted, participant had to leave before ring could be inserted, other), appearance of most recently-used ring (used, not used, not sure, no ring, total), reasons why participants declined study ring, and other reasons why ring was not dispensed.

10.4 Acceptability

Acceptability questions such as the following will be summarized concerning (dis)comfort and changes in sexual feelings from the Final/PUEV ACASI questionnaire: “In the past 3 months, was the vaginal ring taken out because it was causing discomfort?”, “Was the vaginal ring taken out because it was interfering with your sexual pleasure?”, “Was the vaginal ring taken out because it was interfering with your partner’s sexual pleasure?”, “How difficult was it to insert the vaginal ring out the last time you inserted it?”, “How difficult was it to take the vaginal ring out the last time you took it out?”, “ Was the vaginal ring acceptable to your primary partner?”, and “How does the vaginal ring affect your sexual pleasure?”.

10.5 Product Holds

The proportion of women off study product at each study month will be computed based on the Product Hold CRF and presented in tables. In addition, a table describing the reasons for permanent discontinuation of study product will be presented.

10.6 Pregnancy Incidence and Outcomes

Incidence rates of pregnancy (number and person-years) and frequencies of pregnancy outcomes will be summarized in tables based on the Pregnancy Outcome and Pregnancy Report CRFs.

10.7 Sexual Risk Behaviors

Plots showing percentages of participants by study month will be presented for the following relationship and sexual risk behaviors variables from the Behavior Assessment CRF: percentage of participants who had vaginal sex with primary sex partner in the past 3 months, number of vaginal sex acts in the last 7 days, and last act of vaginal sex with a condom. In addition, a table will be presented showing the number of anal sex acts in the past 3 months (none/1 or more), and last act of anal sex with a condom (yes/no).

10.8 Social Impact

Self-reported type of social impact (e.g., personal relationships, partner relationships, travel/immigration, employment, education, medical/dental, housing, other) and the type of impact on the participants’ quality of life (minimal disturbance, moderate disturbance with no significant impact, major disturbance with significant impact) will be summarized in a table.

10.9 Safety Laboratory Results

Safety laboratory results from the Screening Laboratory Results and Quarterly Laboratory Results CRFs will be summarized from the Screening Visit through the last quarterly follow-up. Boxplots of local laboratory values will be generated for baseline values and for values measured over the course of the study. Each boxplot will show the 1st quartile, the median, and the 3rd quartile. Outliers, or values outside the boxplot, will also be plotted. If appropriate, horizontal lines representing boundaries for abnormal values will be plotted.

Laboratory measures will be included as follows: hemogram (white blood cells, hemoglobin, hematocrit, MCV, platelets, WBC), differential (neutrophils, lymphocytes, monocytes, eosinophils, basophils) and chemistries [AST (SGOT), ALT (SGPT), and creatinine].

10.10 Abnormal Pelvic Exam Findings

Follow-up abnormal pelvic exam findings will include the occurrence, per participant, of a finding at any time during follow-up, as shown on the Pelvic Exam CRF. Numbers and proportions of participants with specific types of pelvic exam findings occurring during follow-up will be presented in tables.

10.11 Adverse Experiences

In addition to the primary safety endpoints, adverse experiences reported during follow-up are coded using MedDRA software and will be summarized as follows:

1. The number and percentages of participants with AEs for each severity grade (mild, moderate, severe, potentially life-threatening, or death) for the highest severity grade per participant overall and by MedDRA system organ class (SOC) and preferred term.
2. The number and percentages of AEs for each level of relationship to study product (not related, related) for the most causal relationship per participant overall and by MedDRA SOC and preferred term.
3. The number and percentages of DAIDS expedited adverse experiences and/or ICH serious adverse experiences by severity grade (mild, moderate, severe, potentially life-threatening, or death) for the highest severity grade per participant overall and by MedDRA SOC and preferred term.
4. The number of AEs by severity grade and relationship to study product.

10.12 Protocol Deviations

A table will be presented showing the number and type of protocol deviations based on the Protocol Deviation Log CRF.

10.13 HIV-1 Incidence

A table will be presented showing the number of participants who are not HIV-1 positive at enrollment, and number of participants with no follow-up time after enrollment, the number of participants with any follow-up time after enrollment, the number of participants who have HIV-1 seroconverted, total follow-up time (person-years), and the HIV-1 incidence rate and 95% confidence interval¹ per 100 person-years. Follow-up time will be based on the date of the enrollment visit HIV-1 test result to the date of the first confirmed positive HIV-1 test result, or to the date of the last negative HIV-1 test result received.

11 References

1. Garwood F (1936). Fiducial Limits for the Poisson Distribution. *Biometrika* 46:441-453.

Appendix 1. MTN-020 Visit Windows

All windows are in days; Enrollment date = Day 0; PUEV=Product Use End Visit; SEV=Study Exit Visit

Visit	Visit Code	Target Day	Window Opens	Window Closes
Screening	97.0		28 days prior to Enrollment	
Enrollment	98.0	0 (min of 2 days post-menses)		28 days after Screening Visit
Month 1	01.0	28	14	41
Month 2	02.0	56	42	69
Month 3	03.0	84	70	97
Month 4	04.0	112	98	125
Month 5	05.0	140	126	153
Month 6	06.0	168	154	181
Month 7	07.0	196	182	209
Month 8	08.0	224	210	237
Month 9	09.0	252	238	265
Month 10	10.0	280	266	293
Month 11	11.0	308	294	321
Month 12	12.0	336	322	349
Month 13	13.0	364	350	377
Month 14	14.0	392	378	405
Month 15	15.0	420	406	433
Month 16	16.0	448	434	461
Month 17	17.0	476	462	489
Month 18	18.0	504	490	517
Month 19	19.0	532	518	545
Month 20	20.0	560	546	573
Month 21	21.0	588	574	601
Month 22	22.0	616	602	629

Month 23	23.0	644	630	657
Month 24	24.0	672	658	685
Month 25	25.0	700	686	713
Month 26	26.0	728	714	741
Month 27	27.0	756	742	769
Month 28	28.0	784	770	797
Month 29	29.0	812	798	825
Month 30	30.0	840	826	853
Month 31	31.0	868	854	881
Month 32	32.0	896	882	909
Month 33	33.0	924	910	937
Month 34	34.0	952	938	965
Month 35	35.0	980	966	993
Month 36	36.0	1008	994	1021
Month 37	37.0	1036	1022	1049