1.0 Pre-study Requirements (see page 3)

- Information required by the protocol is reflected on the CRFs
- Information on the CRFs is specified in the protocol
- A protocol specific QA plan is developed
- Training Plan is developed
- Operations manual is developed
- Data system QA Plan is developed
- Data Management Plan is developed
- Statistical Analysis Plan is developed
- Regulatory requirements are satisfied
- Final approval is received to begin trial

2.0 Reporting Structure (identify the lines of communication)

3.0 Roles and Responsibilities (identify protocol staff and their responsibilities)

4.0 Study Binder: Prepare a study binder with the following sections for each participating CTP:

- Protocol and Protocol amendments
- Sample Consent Forms
- Sample of all Case Report Forms (CRF)
- ****Statement of Investigator Obligations, (e.g. FDA 1572 for pharmacotherapy trials)**
- Curriculum Vitae or other statement of qualifications for protocol staff
- Copies of current licenses and or certifications (e.g. M.D., R.N.)
- ****Investigator Brochure (for pharmacotherapy trials)**
- Lab Certification and Lab Normal Values
- Regulatory Documents (e.g. CPA, IRB composition, Certificate of Confidentiality, etc.)
- State Health Department reporting requirements
- ****DEA Certification, when required**
- Safety Reports
- Serious Adverse Event Log
- Location of screening and enrollment logs
- IRB Correspondence (DSMB reports, etc.)
- Site-Sponsor Correspondence (DSMB reports, etc)
- ****Pharmacy Plan (ordering, dispensing, accountability), when required**
- Staff Signature Logs
- Site Visit/Monitor Log
- Communications Log (e.g. protocol clarifications, exemptions, etc)
- Monitor Reports
- Other Correspondence
- Protocol specific Standard Operating Procedures

****Note: For pharmacotherapy trials only**

5.0 Other Site Specific Documents

- Patient Study File (e.g. CRFs, source documents, study flow sheets)
- Other Documents (e.g. location of audio tapes, procedures for randomization,)
- Signed Informed Consent Forms

6.0 Procedures: Include instructions for:

a. Frequency and amount of source document to CRF review.
b. Frequency and amount of CRF to data base review.
c. Audit procedures, use checklists to monitor:
   Protocol required training documentation
   Signed and Dated Informed Consent with supporting note
   Protocol required laboratory and diagnostic evaluations
   Patient eligibility ˚
   Randomization ˚
   Clinical Research Progress notes/Supporting Documentation
   -Deviation from protocol
   -Exceptions from protocol
   -Delivery of intervention and QA procedures
   -Medication administration, accountability, and compliance for pharmacotherapy trials
   Reporting of adverse and serious adverse events to pertinent officials (IRB, NIDA, etc.)
   Timely data entry/corrections
   Follow up on missed appointments
   Protocol defined endpoints documented and followed up ˚
   Study binder maintenance (DSMB reports, IRB correspondence, etc.)
   SOP (study & site specific) maintenance
d. Reporting of audit findings
e. Preparation of study status reports
f. Documenting changes (rules for changing data and retaining records)
g. Follow up of audit findings

7.0 Post Study Requirements

- Study Close Out
- Prepare records for archive
- Data management/analysis plan is followed
- Publication policies and procedures are followed
- Regulatory requirements are satisfied

BASIC EXPLANATION OF PRE-STUDY PLANS/MANUALS

Training Plan: A 1-3 page document, which describes the training which is necessary in order to begin participation in the study. For example, coordinators/research assistants must be familiar with Good Clinical Practice guidelines prior to collecting any study related data. Therapists must be trained in the use of the XXX therapy procedures prior to seeing any participants. This document should also explain the procedure(s) by which replacement personnel will be trained.

Statistical Analysis Plan: This document should describe in detail the types of analyses that can be specified a priori along with any conditional analyses. For example, if baseline severity is different between two groups of subjects, then an analysis of covariance with baseline severity as the covariate will be used. This document should be able to take the analysis of the primary outcome variable(s) directly from the protocol. This document should be finalized prior to freezing of the database (unblinding the study, or disclosing the randomization).

Data System QA Plan: This document should describe the procedures that are used (by each node) to ensure that the information collected is the same as the information sent to NIDA. This document may need to describe more than one procedure or process. For example, if data are collected on paper CRFs, then the data system includes the process by which the data becomes an electronic item, the storage and possible manipulation of that item, and the output of that item for submission to NIDA.

Data Management Plan: This document should describe the procedures that are used to ensure that the data is correct. It should include timings of events (e.g., weekly submission of CRF data, monthly submissions to NIDA, etc.), what rules are being implemented for cleaning the data, logic checks within a form and/or between forms, etc. This document should also include any references to review of case report form data to the electronic data (if applicable). This document may reference the Operations Manual.

Operations Manual: This document should describe the procedures that are required by the protocol, along with their timings relative to other procedures. For example, if orthostatic blood pressure is required by the protocol, then the specifics of how to obtain an orthostatic blood pressure would be specified. This manual may reference the Data Management Plan if references are made to any edit procedures.

QA Plan: This document should describe the quality assurance procedures to be used for the protocol, including the percentage of subjects for whom the source documents will be monitored. For each site (CTP) participating in a protocol, 100% of informed consent documents, 100% of inclusion/exclusion criteria, and 100% of the serious adverse events (SAEs) will be reviewed. In addition, the first 10 subjects at a site (CTP) will have 100% of the case report forms reviewed; and, a minimum of 10% of the subjects will have 100% of the case report forms reviewed thereafter.