Visit date	Study subject ID	Participant initials	
☐☐/☐☐☐/☐☐☐☐ (dd/mon/yyyy)	1701-☐☐☐☐☐-☐☐	☐☐☐☐ E.g. Smith John SMJO	SMART-C
Phone-based visit questionnaire			

Name of the site personnel completing the form:		
Visit (please select the applicable visit):	**☐ Week 4**	**☐ EoT (Week 8)**

SECTION A: ADVERSE EVENTS

1. Have you experienced any side effects since last contact?

☐ No *(skip to question 2)*

☐ Yes *(If yes, please collect data)*

Participant Reported					Nurse Assessment	
AE term	**Severity**	**Action taken with study drug**	**Start date**	**End date**	**Relatedness+**	**SAE?**
	☐ Mild ☐ Moderate* ☐ Severe* ☐ Life threatening*	☐ Drug withdrawn ☐ Drug interrupted ☐ No action ☐ Not applicable	__/___/__ *(dd/mon/yy)*	__/___/__ *(dd/mon/yy)* *or* ☐ Ongoing	☐ Not related ☐ Unlikely ☐ Possibly ☐ Probably	☐ Yes ☐ No
	☐ Mild ☐ Moderate* ☐ Severe* ☐ Life threatening*	☐ Drug withdrawn ☐ Drug interrupted ☐ No action ☐ Not applicable	__/___/__ *(dd/mon/yy)*	__/___/__ *(dd/mon/yy)* *or* ☐ Ongoing	☐ Not related ☐ Unlikely ☐ Possibly ☐ Probably	☐ Yes ☐ No
	☐ Mild ☐ Moderate* ☐ Severe* ☐ Life threatening*	☐ Drug withdrawn ☐ Drug interrupted ☐ No action ☐ Not applicable	__/___/__ *(dd/mon/yy)*	__/___/__ *(dd/mon/yy)* *or* ☐ Ongoing	☐ Not related ☐ Unlikely ☐ Possibly ☐ Probably	☐ Yes ☐ No

+ refer to protocol section 7.2 for definitions of relatedness

***ALL MODERATE, SEVERE AND LIFE THREATENING ADVERSE EVENTS MUST BE REVIEWED BY A SITE INVESTIGATOR.**

Investigator review
Date of review by an investigator: ____/____/_____ Signature of site Investigator ________________________________ Action required? Yes ☐ No ☐ If yes, specify:

Visit date	Study subject ID	Participant initials	
□□/□□□/□□□□ (dd/mon/yyyy)	1701-□□□□□-□□	□□□□ E.g. Smith John SMJO	SMART-C
Phone-based visit questionnaire			

SECTION B: CONCOMITANT MEDICATION

2. Have you started, stopped, or changed any medication since last contact?

☐ No *(skip to Section C)*

☐ Yes *(If yes, please collect data)*

Medication name	Indication	Start date	End date
		__ __/__ __ __/ __ __ *(dd/mon/yy)*	__ __/__ __ __/ __ __ *(dd/mon/yy)* *or* ☐ Ongoing
		__ __/__ __ __/ __ __ *(dd/mon/yy)*	__ __/__ __ __/ __ __ *(dd/mon/yy)* *or* ☐ Ongoing
		__ __/__ __ __/ __ __ *(dd/mon/yy)*	__ __/__ __ __/ __ __ *(dd/mon/yy)* *or* ☐ Ongoing
		__ __/__ __ __/ __ __ *(dd/mon/yy)*	__ __/__ __ __/ __ __ *(dd/mon/yy)* *or* Ongoing
		__ __/__ __ __/ __ __ *(dd/mon/yy)*	__ __/__ __ __/ __ __ *(dd/mon/yy)* *or* Ongoing

Visit date	Study subject ID	Participant initials	
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SECTION C: ADHERENCE QUESTIONNAIRE

3. Since last contact, how many DAYS did you MISS taking GLECAPREVIR/PIBRENTASVIR?

☐

If participant didn't miss any dose, STOP. Otherwise, please continue with next question.

4. Why did you miss taking GLECAPREVIR/PIBRENTASVIR? *Check all that apply.*

Side effects ☐

Forgot to take ☐

Other reason ☐

If other reason, briefly describe reason _____