

Source Document List Version 4.0, August 2021

These study-specific Source Documents are designed to help organize information, serve as a guideline for study procedures and provide a means to capture medical information that may not be recorded elsewhere.

Please note:

- Each study visit and some protocol assessments have an individual set of source documents to assist with the implementation and completion of study procedures
- Once a visit/assessment has been completed, source documents should be reviewed and signed by the PI and filed in the patient's study file/chart
- The use of source documents is not meant to replace the protocol or the patient's medical record/chart. Line through and initial duplicate sections and indicate where source is located
- The source documents may be customized to suit your needs
- All source documents, along with the relevant medical records and images are to be de-identified and sent for adjudication review after Day 35. The site assigned CRA will assist with this process

Provided Source Documents	Additional Information
Dosing and assessments schematic 18g and 36 g	<i>Overview of key items for first 24 hours – 2 versions – non CYP3A inhibitor (18g) regimen and with CYP3A inhibitor (36g) regimen</i>
Visit 1 Screening	<i>Visit 1 (Screening and eligibility)</i>
Lab Draw Worksheet	<i>Central Lab collection documentation for first 24 hours</i>
Visit 2.1. to 2.6 Vital Signs, AEs, ISRs	<i>Vital Sign, AES and ISR documentation for first 24 hours</i>
Infusion 1	<i>Administration of bolus infusion</i>
Infusion 2	<i>Administration of loading infusion</i>
Infusion 3	<i>Administration of maintenance infusion</i>
Infusion 4	<i>Administration of extended dosing if required</i>
Visit 2.5 – 12 hours	<i>12 hours (visit 2.5) source document worksheet (in addition to lab draw worksheet)</i>
Visit 3 – Day 3	<i>Visit 3 source document worksheet</i>
Visit 4 – Day 7	<i>Visit 4 source document worksheet</i>
Visit 5 – Day 35 End of Study_Full Visit	<i>Visit 5 source document worksheet for Full On-Site visit</i>
Visit 5_Day 35_End of Study_Telehealth Visit	<i>Visit 5 source document worksheet if performed as a Telehealth Visit</i>
Visit 5_End of Study_yvisit_Rescheduled On-Site Visit	<i>Visit 5 source document worksheet_End of Study On-Site Visit rescheduled within 30 days of Telehealth Visit</i>
Bleed Location and time hemostasis achieved	<i>Patients enrolled for bleeding - this page is required each time they experience a bleed. Patients enrolled for surgery - this page must be completed if patient had unexpected bleeding, before during or post-surgery.</i>
Surgery Invasive Procedure	<i>Patients requiring urgent surgery or invasive procedure - this page is required for each procedure. Patients enrolled for bleeding - this page must be completed if patient had unexpected surgery or procedures. This page is to include minor, beside supportive measures conducted during the trial as well as estimated blood loss 12 hours post-surgery. Patients who have abnormal bleeding during or post procedure, also complete Bleeding Assessment</i>

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Adverse Event Worksheet	<i>Complete one worksheet per adverse event, review for Adverse Events at every visit.</i>
Prior/Concomitant Therapy Worksheet	<i>Cumulative log to record prior/concomitant therapy for use throughout the study.</i>
Protocol Deviation Log	<i>Record all protocol deviations and actions regarding deviations.</i>