ANTIRETROVIRAL PREGNANCY REGISTRY
REGISTRATION FORM

Fax to: 800-800-1052 (US, Canada)
+910-256-0637 (International) or +32-2-714-5024 (Europe)
00800-5812-1658 (UK, Germany, France)
888-259-5618 (Brazil)

FOR OFFICE USE ONLY (1)
Registry Patient ID _____ HCP ID _____
Prospective ☐ Retrospective ☐ 100% provider ☐
Country _____ State _____
Report type Original U/L ☐ MP ☐ Current U/L ☐ MP ☐
Registry date of notification _____ _____ _____ ☐ Phone

Patient (Log) ID: _____ ***Registry assigned ID number or Sponsor MCN***

Note: To help assure patient anonymity the Registry uses a Registry assigned patient ID to refer to your patient to obtain follow-up and outcome information.

Date patient first seen during this pregnancy
Date: _____ _____ _____ (M D Y)

1. MATERNAL INFORMATION

1.1 Is the patient enrolled in a clinical study? *(treatment or observational study)* ☐ Yes ☐ No ☐ Unknown
If yes, provide the protocol number _____
Was the clinical trial conducted in pregnant women? ☐ Yes ☐ No ☐ Unknown

1.2 Last Menstrual Period _____ _____ _____ (M D Y)

1.3 Corrected EDD _____ _____ _____ *(e.g., by ultrasound* (M D Y)

1.4 Patient Age: _____ *(at conception)*

1.5 Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other (specify) _____

2. PRENATAL TESTS

2.1 Was a prenatal test done?
☐ No *(go to section 3)*
☐ Yes *(complete below and question 2.2)*
Date when test(s) done:

(✓) test(s)		2.2 Is there evidence of a structural defect from one or more of these prenatal tests?
☐	Ultrasound _____ date	☐Yes ☐No ☐Unknown. If yes, Specify defect _____
☐	Ultrasound _____ date	☐Yes ☐No ☐Unknown. If yes, Specify defect _____
☐	Ultrasound _____ date	☐Yes ☐No ☐Unknown. If yes, Specify defect _____
☐	Amniocentesis _____ date	☐Yes ☐No ☐Unknown. If yes, Specify defect _____
☐	MSAFP/serum markers _____ date	☐Yes ☐No ☐Unknown. If yes, Specify defect _____
☐	Other: _____ date	☐Yes ☐No ☐Unknown. If yes, Specify defect _____

☐ Unknown *(go to section 3)*

3. CLINICAL INDICATORS (at the ***START*** of pregnancy)

3.1 Clinical Categories *(√all that apply at the **start** of pregnancy)*:
☐ A. Asymptomatic, acute (primary) HIV or PGL*
☐ B. Symptomatic, not (A) or (C) conditions
☐ C. Other AIDS-indicator conditions and/or CD4<200
☐ D. HIV prophylaxis
☐ E. Hepatitis B (HBV)
☐ F. Hepatitis C (HCV)

*PGL-persistent generalized lymphadenopathy

For additional descriptions of categories refer to the 1993 CDC revised classification system, December 1992 issue of MMWR

3.2 CD4+ T-cell Categories *(at **start** of pregnancy)*
☐ ≥ 500 μL
☐ 200-499 μL
☐ <200 μL
☐ Not applicable

3.3 Hepatitis Severity Indicator *(at **start** of pregnancy):*
☐ A. Compensated liver disease (Pugh score <7)
☐ B. Decompensated liver disease (Pugh score ≥7)
☐ C. Not applicable

Complete applicable information on: ANTIVIRAL THERAPY DURING PREGNANCY Form

HEALTH CARE PROVIDER INFORMATION

Name _____ Specialty _____
Address _____ Phone _____
_____ Fax _____
Alternate Contact _____ Email _____
Provider's Signature _____ Date _____ _____ _____ (M D Y)

Phone: (US, Canada) 800-258-4263 (Toll Free) or 910-256-0238
Phone: (International) +910-256-0238 or (UK, Germany, France) 00800-5913-1359 (Toll Free)
Phone: (Europe): +32-2-714-5028
Internet: www.APRegistry.com
Address: Research Park, 1011 Ashes Drive, Wilmington, NC 28405

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Revised (April 2010)

ANTIRETROVIRAL PREGNANCY REGISTRY
ANTIVIRAL THERAPY DURING PREGNANCY

(Initiated at registration and completed at follow-up)

FOR OFFICE USE ONLY (2)

Registry ID_____

☐ Update

Patient (Log) ID: _____ ***The Registry assigned, non-patient identifying patient ID number or Sponsor MCN***

Complete as much of this page as applicable at Registration. A copy of this form will be sent to you in the expected month of delivery for completion.

4. ANTIVIRAL THERAPY DURING PREGNANCY

1. Use the med. codes below for antiviral medication taken during pregnancy. If not coded, ***Specify Medication****.*

1. Abacavir (ZIAGEN®, ABC)
2. Didanosine (VIDEX®,VIDEX® EC, ddI)
2.1 Didanosine generic – Teva Pharmaceuticals
2.2 Didanosine generic – Aurobindo
2.3 Didanosine generic - Mylan
2.99 Didanosine (unknown manufacturer)
3. Efavirenz (SUSTIVA®, EFV)
3.1 Efavirenz (STOCRIN®, EFV)
3.2 Efavirenz generic - Hetero
3.99 Efavirenz (unknown manufacturer)
4. Lamivudine (EPIVIR®, 3TC)
4.1 Lamivudine generic – Hetero
4.2 Lamivudine+tenofovir df generic - Hetero
4.99 Lamivudine (unknown manufacturer)
5. Lamivudine+zidovudine (COMBIVIR®, ZDV+3TC)
5.1 Lamivudine+zidovudine generic - Hetero
5.99 Lamivudine+zidovudine (unknown manufacturer)
6. Nelfinavir (VIRACEPT®, NFV)
7. Nevirapine (VIRAMUNE®, NVP)
7.1 Nevirapine generic - Hetero
7.99 Nevirapine (unknown manufacturer)
8. Ritonavir (NORVIR®, RTV)
9. Saquinavir (FORTOVASE®, SQV-SGC)
10. Saquinavir mesylate (INVIRASE®, SQV-HGC)
11. Stavudine (ZERIT®, d4T)
11.1 Stavudine generic – Mylan
11.2 Stavudine generic – Aurobindo
11.3 Stavudine generic – Cipla
11.4 Stavudine generic - Hetero
11.99 Stavudine generic – unknown manufacturer
12. Zalcitabine (HIVID®, ddC)
13. Zidovudine (RETROVIR®, ZDV)
13.1 Zidovudine generic - Ranbaxy
13.2 Zidovudine generic – Teva/GSK
13.3 Zidovudine generic – Roxane/BI
13.4 Zidovudine generic – Aurobindo
13.5 Zidovudine generic – Cipla
13.6 Zidovudine generic – Mylan
13.7 Zidovudine generic – Hetero
13.99 Zidovudine (unknown manufacturer)
14. Amprenavir (AGENERASE®, APV)
15. Indinavir (CRIXIVAN®, IDV)
16. Delavirdine mesylate (RESCRIPTOR®, DLV)
17. Lopinavir+ritonavir (KALETRA®, ALUVIA®, LPV/r)
18. Abacavir+lamivudine+zidovudine (TRIZIVIR®, TZV)
19. Tenofovir disoproxil fumarate (VIREAD®, TDF)
19.1 Tenofovir disoproxil fumarate generic - Hetero
20. Adefovir dipivoxil (HEPSERA®, ADV)
21. Enfuvirtide (FUZEON®, T-20)
22. Atazanavir sulfate (REYATAZ®, ATV)
23. Emtricitabine (EMTRIVA®, FTC)
24. Fosamprenavir calcium (LEXIVA®, FOS)
25. Abacavir+lamivudine (EPZICOM®, EPZ)
26. Tenofovir disoproxil fumarate+emtricitabine (TRUVADA®, TVD)
27. Entecavir (BARACLUDE®, ETV)
28. Tipranavir (APTIVUS®, TPV)
29. Efavirenz+tenofovir disoproxil fumarate+emtricitabine (ATRIPLA™, ATR)
30. Telbivudine (TYZEKA®, SEBIVO®, LdT)
31. Darunavir (PREZISTA™, DRV)
32. Raltegravir (ISENTRESS™, RAL)
33. Maraviroc (SELZENTRY™, CELSENTRI™, MVC)
34. Etravirine (INTELENCE™, ETR)

2. In the following table, describe each course or change in route for each applicable therapy.

***Med. Code* (1-34) or if no code indicated, please write medication name and indicate if generic**	***Course***	***Total Daily Dose (mg/day or mg/kg/hr)***	***Route (enter code) 1 = oral 2 = IV 3 = sub-Q***	***Pt Taking Med. at Conception? 1 = Yes 2 = No 3 = Unknown***	***Date Treatment Course Began (M/D/Y) OR Gestational Age Course Began (0 weeks = prior to conception)*** If gestational age, calculation source: ☐ *(LMP)* ☐ *(corrected EDD)*	***Date Treatment Stopped (M/D/Y) OR Ongoing?*** (Note: Ongoing = ongoing Following delivery)
						or ☐ ongoing
						or ☐ ongoing
						or ☐ ongoing
						or ☐ ongoing
						or ☐ ongoing
						or ☐ ongoing

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