Manual of Procedures (MOP)
Section 8. Concomitant Medications

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8.1 OVERVIEW

At the screening visit, the participant is instructed to bring all pill bottles and the research coordinator will review the medications with the participant, inquiring what the medication is used for and reconciling with the medical history. At each subsequent visit, the participant will bring a list of her medications and the bottle(s) of any new medications or supplements. The coordinator will review the list of medications/supplements and will ask participants:

- Since your last visit, have you had any changes to the medications or supplements you are taking? Have you started or stopped or had a change in the dose of your medications or supplements?
- Are you now taking or has your doctor prescribed any of these medications or supplements?
    - Vitamin D containing medications, multivitamins or supplements
    - Calcium containing medications, multivitamins or supplements
    - Medications to treat diabetes.

⇒ All changes in medication and supplement use will be recorded, as described in MOP section 8.4 (but not all medications will be entered in the EDC).

8.2 CONCOMITANT SUPPLEMENTS

8.2.1 Vitamin D Supplementation

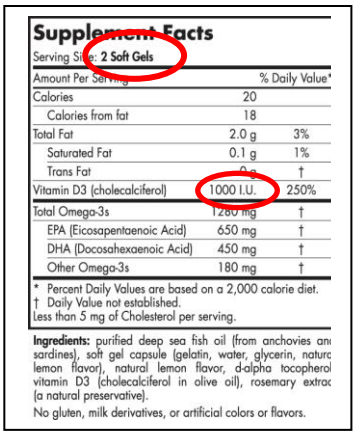
Study personnel will encourage participants to optimize their dietary vitamin D intake and to supplement their dietary intake with vitamin D supplements up to 600 or 800 IU/day (depending on their age), as recommended by the Institute of Medicine.

⇒ Participants will be strongly discouraged from taking vitamin D-containing supplements on their own throughout the trial, beyond what is recommended by the Institute of Medicine for their age group. However, for practical reasons, participants are allowed to take up to 1000 IU/day of vitamin D on their own from all supplemental sources combined (stand-alone vitamin D supplements, multivitamins, medications containing vitamin D [e.g. Fosamax Plus D]), if they wish. The maximum allowable dose of 1000 IU/day was chosen because it is the dosage contained in many commercially available supplements and also the dose most commonly recommended by health care providers.

✓ Therefore, it is critical that study personnel record very carefully the amount of vitamin D in medications and supplements, as described next.

⇒ During the concomitant medication/supplementation review at screening and at each visit, the research coordinator must add up the total dosage of non-dietary vitamin D a participant is taking to make sure the total daily dose does not exceed 1000 IU/day, e.g. 800 IU/day in multivitamin and 2800 IU/week [=400 IU/day] from Fosamax Plus D = 1200 IU/day.

✓ Please note participants should be asked if they take any cod liver oil or fish oil supplements and the bottles should be reviewed for the dose of vitamin D. See example below.



Supplement Facts

Serving Size: 2 Soft Gels

Amount Per Serving		% Daily Value*
Calories	20	
Calories from fat	18	
Total Fat	2.0 g	3%
Saturated Fat	0.1 g	1%
Trans Fat	0 g	†
Vitamin D3 (cholecalciferol)	1000 I.U.	250%
Total Omega-3s	1280 mg	†
EPA (Eicosapentaenoic Acid)	650 mg	†
DHA (Docosahexaenoic Acid)	450 mg	†
Other Omega-3s	180 mg	†

* Percent Daily Values are based on a 2,000 calorie diet.
† Daily Value not established.
Less than 5 mg of Cholesterol per serving.

Ingredients: purified deep sea fish oil (from anchovies and sardines), soft gel capsule (gelatin, water, glycerin, natural lemon flavor), natural lemon flavor, d-alpha tocopherol vitamin D3 (cholecalciferol in olive oil), rosemary extract (a natural preservative).

No gluten, milk derivatives, or artificial colors or flavors.

✓ Participants who are unwilling to limit outside-of-study vitamin D supplementation to 1000 IU/day for the duration of the study will be excluded. There is no limit in how much vitamin D participants can take from food or beverage sources (e.g. dairy products).

NOTE: Site staff should discuss with participants the rationale behind what D2d allows for vitamin D and refer participants to the D2d website for more information. Staff should use the information on the D2d website (d2dstudy.org/about/vitamin-d), and also the appendix "Talking points about vitamin D and calcium" in MOP section 6, as a guide to educate participants and clinicians.

✓ A participant who is taking more than 1000 IU/day of supplemental vitamin D at the screening visit but is willing to lower her supplemental intake to less than 1000 IU/day for the entire study, will be instructed to do so and sites should schedule the Baseline visit so it falls later than 12 weeks since the participant lowered her intake to 1000 IU/day or less.

✓ If during the trial, a participant reports that his physician instructed him to take more than 1000 IU/day of vitamin D from supplements, the physician will be contacted and informed that the participant is in the D2d study and supplementation higher than 1000 IU/day is discouraged, as it is often not indicated. If the physician prescribes the higher dose of vitamin D anyway, the participant will continue in D2d.

8.2.2 Calcium Supplementation

Study personnel will encourage participants to optimize their dietary calcium intake and to supplement their dietary intake with calcium supplements up to 600 mg/day.

⇒ Participants will be discouraged from taking calcium-containing supplements on their own throughout the trial, beyond 600 mg/day. The Institute of Medicine recommends total calcium intake of 1000-1200 mg/day from either food or supplements; however, there is concern that high calcium intakes from supplements may be associated with adverse cardiovascular effects and the current recommendation is to optimize calcium intake through diet with supplementation only as needed to reach the recommended total intake.

⇒ During the concomitant medication/supplementation review at each visit, the research coordinator (or designee) must add up the total dosage of non-dietary calcium a participant is taking to make sure the total daily dose does not exceed 600 mg/day.

✓ During screening, potential participants who are taking more than 600 mg/day of calcium from supplements and are unwilling to lower their intake to less than 600 mg/day during the study will be excluded. There is no limit in how much calcium participants can take from food or beverage sources (e.g. dairy products).

✓ **NOTE:** Site staff should discuss with participants the rationale behind what D2d allows for calcium and refer participants to the D2d website for more information. Staff should use the information on the D2d website (d2dstudy.org/about/vitamin-d), and also the appendix "Talking points about vitamin D and calcium" in MOP section 6, as a guide to educate participants and clinicians.

✓ A participant who is taking more than 600 mg/day of supplemental calcium at the screening visit but is willing to lower her supplemental intake to less than 600 mg/day for the entire study, will be instructed to do so and return for the Baseline visit no earlier than one week.

✓ If during the trial, a participant reports that his physician instructed him to take more than 600 mg/day of calcium from supplements, the physician will be contacted and informed that the participant is in the D2d study and supplementation with calcium higher than 600 mg/day is discouraged, as it is often not indicated. If the physician prescribes the higher dose of calcium anyway, the participant will continue in the study.

8.2.3 Other Supplements

Participants are allowed to take additional vitamins or supplements that *do not contain vitamin D or calcium*. All supplement use (with or without calcium or vitamin D, including fish oils) will be recorded in the source documents, to aid the research staff in calculating amount of supplemental calcium or vitamin D. Supplements do not need to be recorded on the concomitant medication e-CRF. The only exception to this is if a participant takes a **Niacin** supplement *specifically under the direction of her physician to treat high cholesterol* (e.g. not part of a multivitamin or combination supplement), the information should be recorded on the concomitant medication form in EDC (see MOP section 8.5.2).

8.3 CONCOMITANT MEDICATIONS

All concomitant medications a participant takes during the study will be recorded in source documentation.

⇒ *Given the low benefit-to-burden ratio of recording all medication information in EDC, only specific medications of interest to the study will be entered into EDC (see MOP section 8.5.2).*

At screening (or pre-screening), research staff will review all medications (those taken on a regular schedule and those taken as-needed) and reconcile the medications with the D2d study excluded medications list (see MOP section 8.5 and MOP section 18 Appendix). The site physician must review the participant's concomitant medication list prior to randomization. Participants who take any of the excluded medications, either regularly or as-needed, will not be randomized.

If, during the trial, a medication from the D2d excluded medications list is prescribed by a physician, the physician will be contacted and informed that the participant is in the D2d study and the medication is an exclusionary medication. If the physician prescribes the medication anyway, the participant will continue in the study.

8.4 EXCLUDED MEDICATIONS

8.4.1 Anti-hyperglycemic Medications

See list in MOP section 18 Appendix.

8.4.2 Glucocorticoids (IV or oral)*

Hydrocortisone
Methylprednisolone
Prednisone
Dexamethadasone

*Inhaled glucocorticoids are not exclusions. Persons with adrenal insufficiency treated with physiologic doses of glucocorticoids who are otherwise stable are *not* excluded.
*Glucocorticoid injections into a joint or epidural space, are not exclusions; however, visits should be scheduled at least one week after the injection.

8.4.3 Calcium / Vitamin D

Ergocalciferol or cholecalciferol higher than 1000 IU/day
Calcitriol
Paracalcitol

8.4.4 Phosphate Binders

Alternagel, Amphojel, Alu-tab (aluminum hydroxide)
PhosLo (calcium acetate)
Renagel (sevelamer)

8.4.5 Bile Sequestrants

Cholestyramine
Colesevelam

8.4.6 Weight-loss

Orlistat (Alli, Xenical)
Phentermine
Phentermine/topiramate (Qsymia)
Lorcaserin (Belviq)

8.4.7 Other

Rifampin

8.5 DOCUMENTATION OF MEDICATIONS AND SUPPLEMENTS

8.5.1 Source Documentation

For each medication or supplement the participant reports taking (or has taken since the last contact), the following will be recorded in the *source documents*:

- Name of medication or supplement (generic name)
- Indication
- Start date
- Ongoing (yes/no)
- End date
- Dose and units
- Frequency
- Route of administration

At each visit, the medication/supplement list will be reviewed. New medications/supplements will be added and updates will be made.

8.5.2 Electronic Data Capture (EDC) System

⇒ Given the high burden of recording all medication information in EDC, only specific medications approved by the FDA for the following indications will be recorded on the Concomitant Medication e-CRF:

- Hypertension (see below for list of medications)
- Osteoporosis (see below for list of medications)
- Weight-loss (see below for list of medications)
- Cholesterol or lipid lowering (see below for list of medications)
- Diabetes (see section MOP section 18 Appendix for a list of medications)

Below is a list of commonly prescribed medications approved for these indications.

Please note: new medications approved by the FDA may not be included on this list. If you are unsure of the approved indication of a medication, the information can be found in drug reference books, and on the FDA website: http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm?fuseaction=Search.Search_Drug_Name. At the FDA website, you can search for the drug by generic name and then will select the link the link “Label information,” review the most up-to-date label for the “Indications and Usage” section. This section will include a list of the approved indications.

8.5.2.1 Hypertension Medications

Diuretics:
Chlorothiazide (Diuril)
Chlorthalidone
Hydrochlorothiazide (Microzide)
Indapamide
Metolazone (Zaroxolyn)
Bumetanide
Ethacrynic Acid (Edecrin)
Furosemide (Lasix)
Torsemide (Demadex)
Spironolactone (Aldactone)

Angiotensin converting enzyme inhibitors (ACE Inhibitors):
Benazepril (Lotensin)
Captopril (Capoten)
Enalapril (Vasotec)
Fosinopril
Lisinopril (Prinivil, Zestril)
Quinapril (Accupril)
Ramipril (Altace)

Angiotension II receptor blockers:
Candesartan (Atacand)
Eprosartan (Teveten)
Irbesartan (Avapro)
Losartan (Cozaar)
Telmisartan (Micardis)
Valsartan (Diovan)

Beta blockers:
Atenolol (Tenormin)
Metoprolol succinate (Toprol-XL)
Metoprolol tartrate (Lopressor)
Timolol
Nadolol (Corgard)
Pindolol (Visken)
Propranolol (Inderal)

Calcium channel blockers:
Amlodipine (Norvasc)
Isradipine
Nicardipine (Cardene)
Nifedipine (Procardia)
Felodipine (Plendil)

Diltiazem (Cardizem, Dilacor,)
Verapamil (Calan)

Alpha blockers:
Prazosin Hydrochloride
Terazosin Hydrochloride Doxazosin Mesylate(Cardura)

8.5.2.2 Osteoporosis Medications

Alendronate (Fosamax)
Risedronate (Actonel, Atelvia)
Ibandronate (Boniva)
Etidronate (Dridronel)
Tiludronate (Skelid)

8.5.2.3 Weight-loss Medications

Orlistat (Alli, Xenical)
Phentermine
Phentermine/topiramate (Qsymia)
Lorcaserin (Belviq)

8.5.2.4 Cholesterol or Lipid Lowering

Statins:
Lovastatin (Altoprev)
Rosuvastatitn (Crestor)
Fluvastatin (Lescol)
Atorvastatin (Lipitor)
Lovastatin (Mevacor)
Pravastatin (Pravachol)
Simvastatin (Zocor)

Bile acid binding resins:
Colestipol (Colestid)
Cholestyramine/sucrose (Questran)
Colesevelam (Welchol)

Cholesterol absorption Inhibitors:
Exetimibe (Zetia)

Fibrates:
Fenfibrate (Lofibra)
Gemofibrozil (Lopid)
Fenofribrate (TriCor)

Niacin:
Niaspan
Niacin (single component over the counter supplement)

Omega 3 fatty acids:
Lavaza (a prescription omega-3 fatty acid supplement)
Vascepa