[redacted]	Date of Visit:
Dr. [redacted]	Subject ID:

Follow Up Visits

Date of Visit: _____

☐ **Week 4** ☐ **Week 8** ☐ **Week 12** ☐ **Week 18** ☐ **Week 24** ☐ **Week 30**

☐ **Week 36** ☐ **Week 42** ☐ **Week 48** ☐ **Week 54** ☐ **Week 60** ☐ **Week 66**

☐ **Week 72** ☐ **Week 78** ☐ **Week 84** ☐ **Week 90** ☐ **Week 96**

☐ Adverse Events

☐ Concomitant Medications

☐ Validated Investigator's Assessment (vIGA)

☐ Eczema Area Severity Index (EASI)

☐ Tanner Staging (if applicable)

☐ TB Risk Assessment Form/ TB test (Only on Week 48)

☐ Chest X-ray (Only on Week 48)

☐ Vital Signs

☐ Physical Exam (Except week 8)

☐ 12 Lead ECG (Only on Week 48)

☐ Urinalysis

☐ Urine pregnancy test (if applicable)

☐ Blood Draw

☐ PK Samples (If applicable)

☐ Dispense Study Drug

☐ Dispense Home Urine Pregnancy Tests (if applicable)

☐ ClinCard

☐ Scheduling

☐ Requisition

SC: _____

[redacted]	Date of Visit:
Dr. [redacted]	Subject ID:

Adverse Events

Was adverse events chart reviewed? □Yes □No

Concomitant Medications

Was con meds chart reviewed? □Yes □No

Validated global Assessment (vIGA)

Was the assessment done? (separate form): □Yes □No

Eczema Area and Sensitivity Index (EASI)

Was the assessment done? (separate form): □Yes □No

Tanner Staging (Weeks 24, 48, and 72 Only)

Was the assessment done? (separate form): □Yes □No

TB Risk Assessment Form (Only on Week 48)

Was the Risk Assessment Form completed? (separate form): □ Yes □ No

Chest X-ray (only if applicable per TB Risk Assessment Form)

□ Completed: Date/Time: _____ □ N/A

Vital Signs

Blood Pressure: _____/_____ mmHg

Pulse: _____ beats/min

Respiratory Rate: _____ breaths/min

Temperature: _____ □F □C

Weight: _____ □lb □kg

Height: _____ □in □cm

SC: _____

[redacted]	Date of Visit:
Dr. [redacted]	Subject ID:

Physical Exam

(Except Week 8)

Date: _____/_____/_____ Time: _____:_____

Body System	Result	Abnormality
General Appearance	☐ Normal ☐ Abnormal, clinically significant ☐ Not Done ☐ Abnormal, not clinically significant	
Head, Neck, Ears, Nose, Throat, Eyes	☐ Normal ☐ Abnormal, clinically significant ☐ Not Done ☐ Abnormal, not clinically significant	
Dermatologic	☐ Normal ☐ Abnormal, clinically significant ☐ Not Done ☐ Abnormal, not clinically significant	
Cardiovascular	☐ Normal ☐ Abnormal, clinically significant ☐ Not Done ☐ Abnormal, not clinically significant	
Respiratory	☐ Normal ☐ Abnormal, clinically significant ☐ Not Done ☐ Abnormal, not clinically significant	
Abdomen	☐ Normal ☐ Abnormal, clinically significant ☐ Not Done ☐ Abnormal, not clinically significant	
Neurological	☐ Normal ☐ Abnormal, clinically significant ☐ Not Done ☐ Abnormal, not clinically significant	
Musculoskeletal	☐ Normal ☐ Abnormal, clinically significant ☐ Not Done ☐ Abnormal, not clinically significant	
Extremities	☐ Normal ☐ Abnormal, clinically significant ☐ Not Done ☐ Abnormal, not clinically significant	
Lymph Nodes	☐ Normal ☐ Abnormal, clinically significant ☐ Not Done ☐ Abnormal, not clinically significant	
Other (specify):	☐ Normal ☐ Abnormal, clinically significant ☐ Not Done ☐ Abnormal, not clinically significant	

PI Signature: _____ Date: _____

SC: _____

[redacted]	Date of Visit:
Dr. [redacted]	Subject ID:

12-Lead ECG (Only on Week 48)

Date of ECG: _____/_____/_____ Time of ECG: _____:_____

dd mmm yyyy *hh mm*

Investigator's Interpretation:

- ☐ Normal
- ☐ Abnormal, clinically significant
- ☐ Abnormal, not clinically significant
- ☐ Not evaluable

Abnormal Findings:

- ☐ Abnormal rhythm
- ☐ Abnormal conduction
- ☐ Axis QRS >+120
- ☐ Axis QRS < -30
- ☐ Axis indeterminate
- ☐ Left Ventricular hypertrophy
- ☐ Right Ventricular hypertrophy
- ☐ Q wave abnormality
- ☐ ST segment depressed > +1mm ☐ ST segment elevated> =1mm
- ☐ T wave abnormality
- ☐ U wave abnormality
- ☐ QTcF prolongation
- ☐ Other abnormality, specify:

If QTcF prolongation, QTCF = _____msec (M: >430MSEC; F: >450MSEC)

If QTCF prolongation, baseline = _____msec (prior to drug exposure)

Urinalysis

Was the urinalysis performed? □Yes □No

Time performed: _____:_____

PREGNANCY TEST – IF APPLICABLE

Was Pregnancy Test Performed? ☐ YES ☐ NO ☐ N/A

If Yes: Collection Date: _____/_____/_____

dd mmm yyyy

Result: ☐ Positive ☐ Negative

SC: _____

[redacted]	Date of Visit:
Dr. [redacted]	Subject ID:

Test Type: ☐ Serum ☐ Urine

If No: specify ☐ Post-menopausal ☐ Surgically Sterile

Blood Draw

(TB Quantiferons Only on Week 48)

Was the blood draw performed? □Yes □No

Time performed: _____:_____

PK Sampling

(If dose is modified based on analysis of data from Part 2, sample will be collected prior to dosing on visit day and at subsequent visit.)
(Sample will not be collected when dose is changed due to change in subject's weight.)

Was the blood draw performed? □Yes □No

Time performed: _____:_____

Drug Return

Where used kits returned? □Yes □No

If yes, what kits were returned? _____

Drug Dispense & Dosing Review

Formulation: □ tablet □ Solution

Date & Time of second to last dose: _____

Date & Time of last dose: _____

Was study drug dispensed and dosing reviewed? □Yes □No

Was there a change is patient dosing? □Yes □No

Dispense Home Urine Pregnancy Tests

(females of childbearing potential only)

Was the pregnancy tests dispensed? □Yes □N/A

ClinCard Form

Was a clincard form filled out and clincard given? □Yes □No

Scheduling

Was the next visit scheduled? □Yes □No

Requisition Form

Was the requisition form filled out? □Yes □No

SC: _____