

# Recommendations of the Working Group

Findings of the ISCTM Working Group  
February 17, 2016, Washington D.C

# Recommendations of the Working Group (1)

1. Prior to study design, identify types of nonadherence that are likely to produce noninformative data
2. At site selection, eliminate requirements that the majority of Phase 2-4 subjects should come from internal dbs
3. Set limits on the number of previous studies a (Phase 2-4) subject has participated in over a specified time period (e.g. no more than x studies during the past 24 months).
4. Provide PK and treatment assignment information from previous studies in a timely manner to investigators.
5. Utilize an available subject registry to identify and eliminate duplicate and professional subjects.

# Recommendations of the Working Group (2)

6. Eliminate overly restrictive screen-fail ratios, which adversely incentivize investigators.
7. Monitor ratings consistency, diary compliance and subject adherence, and consider an outside adjudication process at screen to improve the patient sample.
8. Consider performing PK sampling on background treatments and consider a biomarker or medication adherence technology during run-in.
9. Pre-specify who will be included in the final analysis based on information available on subjects prior to randomization.

# Recommendations of the Working Group (3)

10. Monitor individual subject adherence with a medication adherence technology, not pill counts alone.
11. Provide subjects and investigators with prompt feedback when nonadherence is detected.
12. Promptly discontinuing subjects who are deceptive, duplicate or egregiously nonadherent may be desirable in order to minimize the impact of the subject's data (MMRM).
13. Consider stratification of subpopulations based on adherence and behavior.
14. Utilize adherence data to inform protocol design and go/no-go decisions in later studies.

# Panel Discussion

- Tom Shiovitz
- Earle Bain
- Phil Skolnick
- Dave McCann
- Tom Laughren
- Adam Hanina