**Active Medication Log Completion Guide**

* The Active Medication Log should be updated whenever the patient's drug regimen is changed. In most cases, the medication log should be updated by the doctor who is prescribing the medication. However, in some situations, a study nurse who is delegated by the doctor may update the medication log on the doctor's behalf.
* The Active Medication Log should start on the treatment start date (see Form completion guide on the treatment start date for a detailed explanation).
  + If the treatment start date is previous to the start date of new TB drugs, then all anti-TB drugs and regimen changes since the treatment start date should be captured retrospectively on the Active Medication Log.

**Anti-TB drugs**

* **Only anti-TB drugs should be entered into this table.** Note: pyridoxine is not an anti-TB drug and therefore should not be entered into this table (it may be entered into the Concomitant Medication Log).
* A drug should be entered into the log when it is prescribed by the doctor. At the beginning of treatment, all drugs in the regimen should be entered into the log.
* **Start date:** Enter the date on which the drug was started. The earliest possible start date is the "treatment start date" (see Treatment Initiation section). In the case of a drug being replaced by a new TB drugs due to an adverse event, the other drugs will have an earlier start date than the new TB drug. For example, if kanamycin is being replaced by bedaquiline, the bedaquiline will have a start date of today, but the other drugs will have earlier start dates. Every effort should be made to retrospectively record all regimen changes from the treatment start date.
* **If a drug is suspended by the doctor** (e.g. suspending Lzd for a period of one week), a stop date should be entered in the appropriate column, and the reason for the suspension should be entered in the last column. If the drug is restarted, it should be written on a new row.
* **If the dose of a drug is changed by the doctor** (e.g. changing Cs from 750 mg daily to 500 mg daily), a stop date should be entered in the row of the old dose, and the reason for the change should be entered in the last column. The drug name, the new dose of the drug, and the start date of that dose should be entered into a new row.
* **If the schedule of a drug is changed by the doctor** (e.g. changing from a daily injectable to Monday-Wednesday-Friday), a stop date should be entered in the row of the old frequency, and the reason for the change should be entered in the last column. The drug name, the new frequency of the drug, and the start date of that frequency should be entered into a new row.
* **Total daily dose**: Write the 'total' daily dose prescribed for the drug, in milligrams. For example, if the dosage is 250 mg in the morning and 250 mg in the evening, then write '500'. If the patient has been prescribed 1 gram of kanamycin daily, then write '1000'.
* **Route**: Select the route of drug administration from the provided options; if it is not included in the provided options, then add details for the route in 'Additional Instructions' column.
* **Schedule**: Select the schedule of drug administration from the provided options; if it is not included in the provided options, then add details for the schedule in 'Additional Instructions' column.
* **Additional Instructions:** Write any additional instructions if required. For example, if route of administration is other than the provided options, then it can be mentioned here. If a drug dose needs to be divided between morning and evening, write it here.
* **AE ID#:** In case a drug needs to be suspended or changed because of an AE, write the AE # from the AE log. This number indicates the specific AE episode for which this drug is being prescribed. If it is unrelated to an AE in the log, then write "NA".

**Concomitant Medication Log**

* This log includes drugs used for management of adverse events, as well as drugs used for management of co-morbidities (e.g. HIV, diabetes). The exact drugs included in this log may differ from site to site.
* A drug should be entered into the log when it is prescribed by the doctor. If a drug is suspended by the doctor, a stop date should be entered in the appropriate column.
* **Drug Quantity and Units**: Write down the drug quantity and units corresponding to a single 'dose'. For example, if a dose is 2 tablets of 100 mg each, then write either: 2 tablets OR 200 mg.
* **Route**: Write the route of drug administration such as oral (PO), Intramuscular (IM), Intravenous (IV), aerosol, subcutaneous (SC), or Other (specify the other route in this form and record it as 'Additional Instructions' in the EMR.
* **Frequency**: Write the prescribed frequency. Options provided in the EMR are: Immediately, Every hour, Every 2/3/4/6/8/12 hours, 2/3/4/5/ times a day, Every other day, 1/2/3/4/5/6/7 days a week, Every 2/3 weeks, Once a month.
  + If the drug is prescribed 'as needed', then write PRN here, and record it in 'Additional Instructions' in the EMR. [NB: frequency is a required field in EMR and will needed to be filled in addition to PRN]
* **Reason for drug administration**: Write 1, 2, 3, or 4, based on the explanation provided in the key. If 4 (Other) written, then explain the reason.
* For drugs used to treat AE that are captured in the AE log, copy the AE # from the AE log. This number indicates the specific AE episode for which this drug is being prescribed. If it is not used to treat an AE in the log, then write "NA".