AN OPEN-LABEL, RANDOMIZED, MULTICENTER PHASE III CLINICAL TRIAL OF SHR-A1811 VERSUS INVESTIGATOR-SELECTED CHEMOTHERAPY FOR PLATINUM-RESISTANT RELAPSED EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER

Blank CRF (Set)

Blank Case Report Form



eCRF Version: Version 1.0

eCRF Date: 27-Mar-2026

Study ID	GSP 402-301 (SHR-A1811-315 extension)
Subject ID	

Subject Information	
Study ID	GSP 402-301 (SHR-A1811-315 Extension)
Site Name	_____
Site ID	_____
Investigator	_____
Informed Consent Date	_____
Subject ID	_____
Subject Status	○ Screening ○ Screen failed ○ Enrolled ○ Follow-Up End of Follow-Up
Protocol Version	_____
eCRF Version	_____
eCRF Status	○ Draft ○ Reviewing ○ Frozen

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Demographics	
Informed Consent Date	_____
Birth Date	_____
Age	Years _____
Sex	○ Male ● Female
Race	○ American Indian or Alaska Native ○ Asian ○ Black or African American ○ Native Hawaiian or Other Pacific Islander ○ White ○ Unknown ○ Not reported ○ Other
Other, Specify	_____
Ethnicity	○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown ○ Not reported
Country	○ India ○ Australia ○ South Korea ○ Others
Other, Specify	_____
Was the female subject with childbearing potential?	○ Yes ○ No
Previous Subject ID	_____
Height	_____
Unit	● cm

Tumor Diagnosis (Ovarian Cancer)	
Anatomical Location	○ Ovary ○ Fallopian Tube ○ Peritoneum
Date of Initial Pathological Diagnosis	_____
Histological Grade at Initial Diagnosis	○ G1 ○ G2 ○ G3 ○ Gx ○ Unknown
Histological Grade at Screening	○ G1 ○ G2 ○ G3 ○ Gx
Pathological Type	○ Serous Carcinoma ○ Endometrioid Carcinoma ○ Mucoid Carcinoma ○ Clear Cell Cancer ○ Malignant Brenner Tumor (Transitional Cell Carcinoma) ○ Non-differentiated Carcinoma ○ Mixed Carcinoma ○ Other, specify ……
Other, Specify	_____
FIGO Staging at Initial Diagnosis	○ I ○ Ia ○ Ib ○ Ic ○Ic1 ○Ic2 ○Ic3 ○ II ○ IIa ○ IIb ○ III ○ IIIa ○ IIIa1 ○ IIIa2 ○ IIIb ○ IIIc ○ IV ○ IVa ○ IVb ○ Unknown
Platinum-resistant Recurrent Date	_____
Most Recent Progression Date	_____

Tumor Diagnosis (HER2 Local Lab)	
Collection Date	_____
ER Result	○ Negative ○ Positive ○ Unknown
PR Result	○ Negative ○ Positive ○ Unknown
HER2 Result (IHC)	○ 0 ○ 1+ ○ 2+ ○ 3+ ○ Unknown
HER2 Result (ISH)	○ Negative ○ Positive ○ Unknown

Tumor Diagnosis (BRCA1/2)	
Specimen Type	○ Blood ○ Tissue ○ Blood and Tissue
Collection Date	_____
BRCA1/2 Mutation	○ Associated with germ line BRCA1/2 pathogenic or suspected pathogenic mutations (gBRCA1/2) ○ Associated with tumor BRCA1/2 pathogenic or suspected pathogenic mutations (tBRCA1/2) ○ No germ line BRCA1/2 pathogenic or suspected pathogenic mutations (gBRCA1/2) ○ No tumor BRCA1/2 pathogenic or suspected pathogenic mutations (tBRCA1/2)

Prior Cancer Systemic Therapy	
Treatment Setting	○ Neoadjuvant ○ Adjuvant ○ Maintenance ○ Advanced/Metastatic
Line of Therapy	○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ >6
Other Line,Specify	_____
Regimen (s)	_____
Number of Treatment Cycle (s)	_____
Date of Progressive Disease	_____
Outcome of the Treatment	○ Progressive Disease ○ Toxicity Intolerance ○ Treatment Completed ○ Unknown ○ Other
Other Outcome, Specify	_____

Prior Cancer Systemic Therapy Detail

#	Medication Name	Type of Treatment	Other Type, Specify	Dose	Unit	Other Unit, Specify	Frequency	Other Frequency, Specify	Start Date	End Date

Screening

		Chemotherapy Endocrine Therapy Immunotherapy PARP Inhibitors Anti-HER2 Targeted Therapy Anti-VEGF/VEGFR Targeted Therapy Targeted Therapy Other			mg ug mL g IU mg/kg mg/m2 Tablet Capsule Inhalation Drop Other		Daily (QD) Twice Daily (BID) Three Times Daily (TID) Four Times Daily (QID) Every night Every Other Day (QOD) Once Weekly (QS) Twice Weekly (BIS) Three Times Weekly (TIS) Four Times Weekly (QIS) Every 2 Weeks (Q2S) Every 3 Weeks (Q3S) Every 4 Weeks (Q4S) Monthly (QM) ONCE As Needed (PRN) Other			

Prior Locoregional Therapy	
Category of Treatment	○ Transarterial Chemoembolization (TACE) ○ Transhepatic Arterial Infusion (TAI) ○ Transarterial Embolization (TAE) ○ Radiofrequency Ablation (RFA) ○ Microwave Ablation (MWA) ○ Percutaneous Ethanol Injection (PEI) ○ Cryoablation (CRA) ○ High Power Focused Ultrasound Ablation (HIFU) ○ Radioactive Seed Implantation ○ Hyperthermic Peritoneal Perfusion(CHPP) ○ Hyperthermic Intraperitoneal Peroperative Chemotherapy(HIPEC) ○ Other
Other, Specify	_____
Start Date	_____
End Date	_____
Response Assessment	○ CR ○ PR ○ SD ○ Non-CR/Non-PD ○ PD ○ NE
Ablation Response	○ Complete Response ○ Incomplete Response ○ Unknown
Was Any Medication Taken?	○ Yes ○ No

Prior Locoregional Therapy Detail	
#	Medication Name

Prior Cancer Radiotherapy	
Treatment Setting	○ Curative ○ Neoadjuvant ○ Adjuvant ○ Palliative ○ Other
Other Setting, Specify	_____
Location	☐ Brain ☐ Esophagus ☐ Stomach ☐ Small Intestine ☐ Colon ☐ Rectum ☐ Liver ☐ Gallbladder ☐ Bile Duct ☐ Pancreas ☐ Lung ☐ Trachea ☐ Breast ☐ Ovary ☐ Fallopian Tube ☐ Uterus ☐ Cervix Uteri ☐ Vagina ☐ Kidney ☐ Ureter ☐ Bladder ☐ Urethra ☐ Thyroid Gland ☐ Adrenal Gland ☐ Spleen ☐ Lymph Node ☐ Pericardium ☐ Pleura ☐ Peritoneum ☐ Pericardial Effusion ☐ Pleural Effusion ☐ Peritoneal Effusion ☐ Bone ☐ Soft Tissue ☐ Skin ☐ Other
Other Location, Specify	_____
Start Date	_____
End Date	_____
Total Dose	_____
Unit	○ cGy ○ Gy
Response Assessment After Radiotherapy	○ CR ○ PR ○ SD ○ Non-CR/Non-PD ○ PD ○ NE ○ Unknown

Prior Cancer Surgery	
Surgery Name	_____
Surgery Date	_____
Intent of Surgery	○ Diagnostic ○ Curative ○ Palliative ○ Other
Other Intent, Specify	_____
Location	☐ Brain ☐ Esophagus ☐ Stomach ☐ Small Intestine ☐ Colon ☐ Rectum ☐ Liver ☐ Gallbladder ☐ Bile Duct ☐ Pancreas ☐ Lung ☐ Trachea ☐ Breast ☐ Ovary ☐ Fallopian Tube ☐ Uterus ☐ Cervix Uteri ☐ Vagina ☐ Kidney ☐ Ureter ☐ ☐ Bladder ☐ Urethra ☐ Thyroid Gland ☐ Adrenal Gland ☐ Spleen ☐ Lymph Node ☐ Pericardium ☐ Pleura ☐ Peritoneum ☐ Pericardial Effusion ☐ Pleural Effusion ☐ Peritoneal Effusion ☐ Bone ☐ Soft Tissue ☐ Skin ☐ Other
Other Location, Specify	_____

Medical History	
Medical History Term	_____
Start Date	_____
Ongoing	○ Yes ○ No
End Date	_____

Biomarker Collection	
Was the Specimen Collected?	○ Yes ○ No
Test Name	□ HER2 Test □ FISH Test
Collection Date	_____
Specimen Type	○ Fresh Biopsy ○ Archived Tissue
Pre-Screen ID	_____

Physical Examination

Exam Date _____

Physical Examination Detail

#	Body System	Result	Abnormal Findings
1	General Status	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
2	Head and Face	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
3	Skin	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
4	Lymph Node	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
5	Eyes	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
6	Ears	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
7	Nose	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
8	Throat	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
9	Oral Cavity	○ Normal ○ Abnormal, Not Clinically Significant	

		○ Abnormal, Clinically Significant	
10	Respiratory System	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
11	Cardiovascular System	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
12	Abdomen	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
13	Urogenital System	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
14	Musculoskeletal	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
15	Neurological	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
16	Mental Status	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Erythrocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
5	Hemoglobin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Platelets			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Uric Acid			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Amylase and Lipase

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Amylase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Lipase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes _U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Erythrocytes_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Occult Blood_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Stool Analysis

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Fecal Occult Blood			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Fibrinogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	D-Dimer			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Thyroid Function

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Triiodothyronine, Free			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Thyroxine, Free			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Thyrotropin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Myocardial Zymogram

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Creatine Kinase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Creatine Kinase MB			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Troponin I			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Troponin T			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	ProB-type Natriuretic Peptide			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Brain Natriuretic Peptide			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

Echocardiography	
Exam Date	_____
LVEF	_____
Unit	● %
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

Enrollment	
Protocol Version at Screening	_____
Eligibility Status	○ Screen Success ○ Screen Failure
Treatment in Control Group	○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
Reason for Screen Failure	○ Adverse Event ○ Failure to Meet Eligibility Criteria ○ Lost to Follow-up ○ Withdrawal by Subject ○ Other
Other, Specify	_____

Enrollment Detail

#	Criterion Type	Exception Criterion Identifier
	○ Inclusion Criteria	○ IC1 ○ IC2 ○ IC3 ○ IC4 ○ IC5 ○ IC6 ○ IC7 ○ IC8 ○ IC9 ○ IC10 ○ IC11a ○ IC11b ○ IC11c ○ IC11d ○ IC11e ○ IC11f ○ IC11g ○ IC11h ○ IC12
	○ Inclusion Criteria	○ EC1 ○ EC2 ○ EC3 ○ EC4 ○ EC5 ○ EC6 ○ EC7 ○ EC8 ○ EC9 ○ EC10 ○ EC11 ○ EC12 ○ EC13 ○ EC14 ○ EC15 ○ EC16 ○ EC17 ○ EC18 ○ EC19 ○ EC20 ○ EC21 ○ EC22 ○ EC23 ○ EC24

Stratification Factor	
HER2 IHC expression	○ 1+ ○ 2+/3+
Treatment of VEGF/VEGFR inhibitor	○ Yes ○ No

Randomization	
Was the subject randomized?	○ No ○ Yes
Randomization ID	_____
Randomization Date	_____
Treatment Arm	○ Experimental Group ○ Control Group

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Erythrocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
5	Hemoglobin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Platelets			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Erythrocytes_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Occult Blood_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Fibrinogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	D-Dimer			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

EQ-5D-5L	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
Mobility	○ I have no problems in walking ○ I have slight problems in walking ○ I have moderate problems in walking ○ I have severe problems in walking ○ I am unable to walk ○ Not Done
Self-care	○ I have no problems bathing or dressing myself ○ I have slight problems bathing or dressing myself ○ I have moderate problems bathing or dressing myself ○ I have severe problems bathing or dressing myself ○ I am unable to bathe or dress myself ○ Not Done
Usual Activities (e.g.work,study, housework,family or leisure activities)	○ I have no problems doing my usual activities ○ I have slight problems doing my usual activities ○ I have moderate problems doing my usual activities ○ I have severe problems doing my usual activities ○ I am unable to do my usual activities ○ Not Done
Pain/Discomfort	○ I have no pain or discomfort ○ I have slight pain or discomfort ○ I have moderate pain or discomfort ○ I have severe pain or discomfort ○ I have extreme pain or discomfort ○ Not Done
Anxiety/Depression	○ I am not anxious or depressed ○ I am slightly anxious or depressed ○ I am moderately anxious or depressed ○ I am severely anxious or depressed ○ I am extremely anxious or depressed ○ Not Done
Your Health Today	_____

FACT-OSI	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
I Have a Lack of Energy	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Been Vomiting	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I have Pain	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Nausea	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Swelling in my Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I worry that my condition Will Get Worse	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I am content with the quality of My Life Right now	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Cramps in My Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

SHR-A1811 PK Sample collection	
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

SHR169265 PK Sample Collection(Within 2h Pre-Dose)	
Planned Time Point Name	● Within 2h Pre-Dose 5min Post Dose
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

SHR169265 PK Sample Collection(5min Post Dose)	
Planned Time Point Name	○ Within 2h Pre-Dose 5min Post Dose
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

SHR-A1811 ADA Sample Collection	
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Erythrocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
5	Hemoglobin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Platelets			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Erythrocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
5	Hemoglobin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Platelets			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Erythrocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
5	Hemoglobin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Platelets			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Erythrocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
5	Hemoglobin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Platelets			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

SHR-A1811 PK Sample collection	
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

SHR169265 PK Sample Collection(Within 2h Pre-Dose)	
Planned Time Point Name	● Within 2h Pre-Dose 5min Post Dose
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

SHR169265 PK Sample Collection(5min Post Dose)	
Planned Time Point Name	○ Within 2h Pre-Dose 5min Post Dose
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Erythrocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
5	Hemoglobin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Platelets			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Erythrocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
5	Hemoglobin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Platelets			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Erythrocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
5	Hemoglobin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Platelets			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	0-Fully active, able to carry on all pre-disease performance without restriction 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

EQ-5D-5L	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
Mobility	○ I have no problems in walking ○ I have slight problems in walking ○ I have moderate problems in walking ○ I have severe problems in walking ○ I am unable to walk ○ Not Done
Self-care	○ I have no problems bathing or dressing myself ○ I have slight problems bathing or dressing myself ○ I have moderate problems bathing or dressing myself ○ I have severe problems bathing or dressing myself ○ I am unable to bathe or dress myself ○ Not Done
Usual Activities (e.g.work,study, housework,family or leisure activities)	○ I have no problems doing my usual activities ○ I have slight problems doing my usual activities ○ I have moderate problems doing my usual activities ○ I have severe problems doing my usual activities ○ I am unable to do my usual activities ○ Not Done
Pain/Discomfort	○ I have no pain or discomfort ○ I have slight pain or discomfort ○ I have moderate pain or discomfort ○ I have severe pain or discomfort ○ I have extreme pain or discomfort ○ Not Done
Anxiety/Depression	○ I am not anxious or depressed ○ I am slightly anxious or depressed ○ I am moderately anxious or depressed ○ I am severely anxious or depressed ○ I am extremely anxious or depressed ○ Not Done
Your Health Today	_____

FACT-OSI	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
I Have a Lack of Energy	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Been Vomiting	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I have Pain	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Nausea	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Swelling in my Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I worry that my condition Will Get Worse	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I am content with the quality of My Life Right now	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Cramps in My Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Thyroid Function						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Triiodothyronine, Free			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Thyroxine, Free			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Thyrotropin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Myocardial Zymogram						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Creatine Kinase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Creatine Kinase MB			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Troponin I			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Troponin T			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	ProB-type Natriuretic Peptide			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Brain Natriuretic Peptide			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

Echocardiography	
Exam Date	_____
LVEF	_____
Unit	● %
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

EQ-5D-5L	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
Mobility	○ I have no problems in walking ○ I have slight problems in walking ○ I have moderate problems in walking ○ I have severe problems in walking ○ I am unable to walk ○ Not Done
Self-care	○ I have no problems bathing or dressing myself ○ I have slight problems bathing or dressing myself ○ I have moderate problems bathing or dressing myself ○ I have severe problems bathing or dressing myself ○ I am unable to bathe or dress myself ○ Not Done
Usual Activities (e.g.work,study, housework,family or leisure activities)	○ I have no problems doing my usual activities ○ I have slight problems doing my usual activities ○ I have moderate problems doing my usual activities ○ I have severe problems doing my usual activities ○ I am unable to do my usual activities ○ Not Done
Pain/Discomfort	○ I have no pain or discomfort ○ I have slight pain or discomfort ○ I have moderate pain or discomfort ○ I have severe pain or discomfort ○ I have extreme pain or discomfort ○ Not Done
Anxiety/Depression	○ I am not anxious or depressed ○ I am slightly anxious or depressed ○ I am moderately anxious or depressed ○ I am severely anxious or depressed ○ I am extremely anxious or depressed ○ Not Done
Your Health Today	_____

FACT-OSI	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
I Have a Lack of Energy	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Been Vomiting	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I have Pain	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Nausea	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Swelling in my Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I worry that my condition Will Get Worse	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I am content with the quality of My Life Right now	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Cramps in My Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Was the planned dose adjusted?	Yes ○ No
Number of Units	_____
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significanc e	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatas e			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotran sferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significanc e	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatas e			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotran sferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

SHR-A1811 PK Sample collection	
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

SHR169265 PK Sample Collection(Within 2h Pre-Dose)	
Planned Time Point Name	● Within 2h Pre-Dose 5min Post Dose
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

SHR-A1811 ADA Sample Collection	
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

EQ-5D-5L	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
Mobility	○ I have no problems in walking ○ I have slight problems in walking ○ I have moderate problems in walking ○ I have severe problems in walking ○ I am unable to walk ○ Not Done
Self-care	○ I have no problems bathing or dressing myself ○ I have slight problems bathing or dressing myself ○ I have moderate problems bathing or dressing myself ○ I have severe problems bathing or dressing myself ○ I am unable to bathe or dress myself ○ Not Done
Usual Activities (e.g.work,study, housework,family or leisure activities)	○ I have no problems doing my usual activities ○ I have slight problems doing my usual activities ○ I have moderate problems doing my usual activities ○ I have severe problems doing my usual activities ○ I am unable to do my usual activities ○ Not Done
Pain/Discomfort	○ I have no pain or discomfort ○ I have slight pain or discomfort ○ I have moderate pain or discomfort ○ I have severe pain or discomfort ○ I have extreme pain or discomfort ○ Not Done
Anxiety/Depression	○ I am not anxious or depressed ○ I am slightly anxious or depressed ○ I am moderately anxious or depressed ○ I am severely anxious or depressed ○ I am extremely anxious or depressed ○ Not Done
Your Health Today	_____

FACT-OSI	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
I Have a Lack of Energy	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Been Vomiting	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I have Pain	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Nausea	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Swelling in my Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I worry that my condition Will Get Worse	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I am content with the quality of My Life Right now	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Cramps in My Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significanc e	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatas e			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotran sferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significanc e	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatas e			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotran sferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Thyroid Function						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Triiodothyronine, Free			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Thyroxine, Free			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Thyrotropin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Myocardial Zymogram

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Creatine Kinase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Creatine Kinase MB			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Troponin I			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Troponin T			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	ProB-type Natriuretic Peptide			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Brain Natriuretic Peptide			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

Echocardiography	
Exam Date	_____
LVEF	_____
Unit	● %
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

EQ-5D-5L	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
Mobility	○ I have no problems in walking ○ I have slight problems in walking ○ I have moderate problems in walking ○ I have severe problems in walking ○ I am unable to walk ○ Not Done
Self-care	○ I have no problems bathing or dressing myself ○ I have slight problems bathing or dressing myself ○ I have moderate problems bathing or dressing myself ○ I have severe problems bathing or dressing myself ○ I am unable to bathe or dress myself ○ Not Done
Usual Activities (e.g.work,study, housework,family or leisure activities)	○ I have no problems doing my usual activities ○ I have slight problems doing my usual activities ○ I have moderate problems doing my usual activities ○ I have severe problems doing my usual activities ○ I am unable to do my usual activities ○ Not Done
Pain/Discomfort	○ I have no pain or discomfort ○ I have slight pain or discomfort ○ I have moderate pain or discomfort ○ I have severe pain or discomfort ○ I have extreme pain or discomfort ○ Not Done
Anxiety/Depression	○ I am not anxious or depressed ○ I am slightly anxious or depressed ○ I am moderately anxious or depressed ○ I am severely anxious or depressed ○ I am extremely anxious or depressed ○ Not Done
Your Health Today	_____

FACT-OSI	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
I Have a Lack of Energy	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Been Vomiting	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I have Pain	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Nausea	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Swelling in my Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I worry that my condition Will Get Worse	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I am content with the quality of My Life Right now	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Cramps in My Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significanc e	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Absolute Lymphocyt e Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Erythrocyt es			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Hemoglobin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Platelets			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significanc e	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatas e			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotran sferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

EQ-5D-5L	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
Mobility	○ I have no problems in walking ○ I have slight problems in walking ○ I have moderate problems in walking ○ I have severe problems in walking ○ I am unable to walk ○ Not Done
Self-care	○ I have no problems bathing or dressing myself ○ I have slight problems bathing or dressing myself ○ I have moderate problems bathing or dressing myself ○ I have severe problems bathing or dressing myself ○ I am unable to bathe or dress myself ○ Not Done
Usual Activities (e.g.work,study, housework,family or leisure activities)	○ I have no problems doing my usual activities ○ I have slight problems doing my usual activities ○ I have moderate problems doing my usual activities ○ I have severe problems doing my usual activities ○ I am unable to do my usual activities ○ Not Done
Pain/Discomfort	○ I have no pain or discomfort ○ I have slight pain or discomfort ○ I have moderate pain or discomfort ○ I have severe pain or discomfort ○ I have extreme pain or discomfort ○ Not Done
Anxiety/Depression	○ I am not anxious or depressed ○ I am slightly anxious or depressed ○ I am moderately anxious or depressed ○ I am severely anxious or depressed ○ I am extremely anxious or depressed ○ Not Done
Your Health Today	_____

FACT-OSI	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
I Have a Lack of Energy	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Been Vomiting	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I have Pain	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Nausea	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Swelling in my Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I worry that my condition Will Get Worse	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I am content with the quality of My Life Right now	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Cramps in My Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significanc e	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatas e			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotran sferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Thyroid Function

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Triiodothyronine, Free			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Thyroxine, Free			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Thyrotropin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Myocardial Zymogram

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Creatine Kinase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Creatine Kinase MB			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Troponin I			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Troponin T			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	ProB-type Natriuretic Peptide			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Brain Natriuretic Peptide			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

Echocardiography	
Exam Date	_____
LVEF	_____
Unit	● %
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

EQ-5D-5L	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
Mobility	○ I have no problems in walking ○ I have slight problems in walking ○ I have moderate problems in walking ○ I have severe problems in walking ○ I am unable to walk ○ Not Done
Self-care	○ I have no problems bathing or dressing myself ○ I have slight problems bathing or dressing myself ○ I have moderate problems bathing or dressing myself ○ I have severe problems bathing or dressing myself ○ I am unable to bathe or dress myself ○ Not Done
Usual Activities (e.g.work,study, housework,family or leisure activities)	○ I have no problems doing my usual activities ○ I have slight problems doing my usual activities ○ I have moderate problems doing my usual activities ○ I have severe problems doing my usual activities ○ I am unable to do my usual activities ○ Not Done
Pain/Discomfort	○ I have no pain or discomfort ○ I have slight pain or discomfort ○ I have moderate pain or discomfort ○ I have severe pain or discomfort ○ I have extreme pain or discomfort ○ Not Done
Anxiety/Depression	○ I am not anxious or depressed ○ I am slightly anxious or depressed ○ I am moderately anxious or depressed ○ I am severely anxious or depressed ○ I am extremely anxious or depressed ○ Not Done
Your Health Today	_____

FACT-OSI	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
I Have a Lack of Energy	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Been Vomiting	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I have Pain	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Nausea	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Swelling in my Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I worry that my condition Will Get Worse	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I am content with the quality of My Life Right now	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Cramps in My Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

EQ-5D-5L	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
Mobility	○ I have no problems in walking ○ I have slight problems in walking ○ I have moderate problems in walking ○ I have severe problems in walking ○ I am unable to walk ○ Not Done
Self-care	○ I have no problems bathing or dressing myself ○ I have slight problems bathing or dressing myself ○ I have moderate problems bathing or dressing myself ○ I have severe problems bathing or dressing myself ○ I am unable to bathe or dress myself ○ Not Done
Usual Activities (e.g.work,study, housework,family or leisure activities)	○ I have no problems doing my usual activities ○ I have slight problems doing my usual activities ○ I have moderate problems doing my usual activities ○ I have severe problems doing my usual activities ○ I am unable to do my usual activities ○ Not Done
Pain/Discomfort	○ I have no pain or discomfort ○ I have slight pain or discomfort ○ I have moderate pain or discomfort ○ I have severe pain or discomfort ○ I have extreme pain or discomfort ○ Not Done
Anxiety/Depression	○ I am not anxious or depressed ○ I am slightly anxious or depressed ○ I am moderately anxious or depressed ○ I am severely anxious or depressed ○ I am extremely anxious or depressed ○ Not Done
Your Health Today	_____

FACT-OSI	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
I Have a Lack of Energy	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Been Vomiting	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I have Pain	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Nausea	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Swelling in my Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I worry that my condition Will Get Worse	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I am content with the quality of My Life Right now	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Cramps in My Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

SHR-A1811 PK Sample collection	
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

SHR169265 PK Sample Collection(Within 2h Pre-Dose)	
Planned Time Point Name	● Within 2h Pre-Dose 5min Post Dose
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

SHR-A1811 ADA Sample Collection	
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Urinalysis

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Urinalysis

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Thyroid Function

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Triiodothyronine, Free			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Thyroxine, Free			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Thyrotropin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Myocardial Zymogram

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Creatine Kinase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Creatine Kinase MB			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Troponin I			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Troponin T			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	ProB-type Natriuretic Peptide			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Brain Natriuretic Peptide			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

Echocardiography	
Exam Date	_____
LVEF	_____
Unit	● %
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

EQ-5D-5L	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
Mobility	○ I have no problems in walking ○ I have slight problems in walking ○ I have moderate problems in walking ○ I have severe problems in walking ○ I am unable to walk ○ Not Done
Self-care	○ I have no problems bathing or dressing myself ○ I have slight problems bathing or dressing myself ○ I have moderate problems bathing or dressing myself ○ I have severe problems bathing or dressing myself ○ I am unable to bathe or dress myself ○ Not Done
Usual Activities (e.g.work,study, housework,family or leisure activities)	○ I have no problems doing my usual activities ○ I have slight problems doing my usual activities ○ I have moderate problems doing my usual activities ○ I have severe problems doing my usual activities ○ I am unable to do my usual activities ○ Not Done
Pain/Discomfort	○ I have no pain or discomfort ○ I have slight pain or discomfort ○ I have moderate pain or discomfort ○ I have severe pain or discomfort ○ I have extreme pain or discomfort ○ Not Done
Anxiety/Depression	○ I am not anxious or depressed ○ I am slightly anxious or depressed ○ I am moderately anxious or depressed ○ I am severely anxious or depressed ○ I am extremely anxious or depressed ○ Not Done
Your Health Today	_____

FACT-OSI	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
I Have a Lack of Energy	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Been Vomiting	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I have Pain	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Nausea	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Swelling in my Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I worry that my condition Will Get Worse	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I am content with the quality of My Life Right now	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Cramps in My Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Urinalysis

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Urinalysis						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

EQ-5D-5L	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
Mobility	○ I have no problems in walking ○ I have slight problems in walking ○ I have moderate problems in walking ○ I have severe problems in walking ○ I am unable to walk ○ Not Done
Self-care	○ I have no problems bathing or dressing myself ○ I have slight problems bathing or dressing myself ○ I have moderate problems bathing or dressing myself ○ I have severe problems bathing or dressing myself ○ I am unable to bathe or dress myself ○ Not Done
Usual Activities (e.g.work,study, housework,family or leisure activities)	○ I have no problems doing my usual activities ○ I have slight problems doing my usual activities ○ I have moderate problems doing my usual activities ○ I have severe problems doing my usual activities ○ I am unable to do my usual activities ○ Not Done
Pain/Discomfort	○ I have no pain or discomfort ○ I have slight pain or discomfort ○ I have moderate pain or discomfort ○ I have severe pain or discomfort ○ I have extreme pain or discomfort ○ Not Done
Anxiety/Depression	○ I am not anxious or depressed ○ I am slightly anxious or depressed ○ I am moderately anxious or depressed ○ I am severely anxious or depressed ○ I am extremely anxious or depressed ○ Not Done
Your Health Today	_____

FACT-OSI	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
I Have a Lack of Energy	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Been Vomiting	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I have Pain	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Nausea	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Swelling in my Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I worry that my condition Will Get Worse	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I am content with the quality of My Life Right now	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Cramps in My Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Urinalysis						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Erythrocytes_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Occult Blood_U			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Coagulation						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Fibrinogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	D-Dimer			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

SHR-A1811 Administration	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Kit Number	○ Kit 1 _____ ○ Kit 2 _____ ○ Kit 3 _____ ○ Kit 4 _____ ○ Kit 5 _____ ○ Kit 6 _____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4.8mg/kg ○ 4.0mg/kg ○ 3.2mg/kg
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____
End Time	_____

Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Doxorubicin Hydrochloride Administration	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 40 ○ 30 ○ 20 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Gemcitabine Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 1000 ○ 750 ○ 500 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Topotecan Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	○ Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	○ Yes ○ No
If yes, please provide the reason for dose adjustment	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 4 ○ 3.5 ○ 3 ○ Other
Other Planned Dose Level	_____
Unit	● mg/m^2
Planned Dose	_____
Unit	● mg
Actual Dose	_____
Unit	● mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Erythrocytes			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Hemoglobin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Platelets			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
2	Protein			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
3	Alkaline Phosphatase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
4	Alanine Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
6	Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
8	Direct Bilirubin			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
9	Triglycerides			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

10	Cholesterol			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
11	Urea			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
12	Urea nitrogen			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
13	Creatinine			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
14	Urate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

15	Potassium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
16	Sodium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
17	Chloride			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
18	Calcium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
19	Magnesium			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

20	Phosphate			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			Normal Abnormal, Not Clinically Significant Abnormal, Clinically Significant		

Paclitaxel Administration	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
If study treatment was not administered as scheduled, specify the status	Not Taken ○ Delayed Administration
If delayed or not taken, please provide the reason	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Lot Number	_____
Number of Units	_____
Was the planned dose adjusted?	Yes ○ No
If yes, please provide the reason for dose adjustment	Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____
Planned Dose Level	○ 80 ○ 70 ○ 60 ○ Other
Other Planned Dose Level	_____
Unit	mg/m^2
Planned Dose	_____
Unit	mg
Actual Dose	_____
Unit	mg
Start Date	_____
Start Time	_____
End Date	_____

End Time	_____
Was the infusion interrupted?	○ Yes ○ No
If yes, please provide the reason for infusion interruption	○ Adverse Event ○ Other
If AE, please specify AE Number	_____
If other, please specify	_____

Visit Date	
Was the visit done?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Visit Date	_____

Physical Examination

Exam Date

_____

Physical Examination Detail

#	Body System	Result	Abnormal Findings
1	General Status	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
2	Head and Face	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
3	Skin	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
4	Lymph Node	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
5	Eyes	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
6	Ears	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
7	Nose	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
8	Throat	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
9	Oral Cavity	○ Normal ○ Abnormal, Not Clinically Significant	

		○ Abnormal, Clinically Significant	
10	Respiratory System	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
11	Cardiovascular System	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
12	Abdomen	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
13	Urogenital System	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
14	Musculoskeletal	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
15	Neurological	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
16	Mental Status	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Erythrocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Hemoglobin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Platelets			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Erythrocytes_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Occult Blood_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Stool Analysis

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Fecal Occult Blood			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Coagulation						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Fibrinogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	D-Dimer			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Thyroid Function						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Triiodothyronine, Free			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Thyroxine, Free			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Thyrotropin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Myocardial Zymogram

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Creatine Kinase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Creatine Kinase MB			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Troponin I			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Troponin T			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	ProB-type Natriuretic Peptide			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Brain Natriuretic Peptide			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

Echocardiography	
Exam Date	_____
LVEF	_____
Unit	● %
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

EQ-5D-5L	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
Mobility	○ I have no problems in walking ○ I have slight problems in walking ○ I have moderate problems in walking ○ I have severe problems in walking ○ I am unable to walk ○ Not Done
Self-care	○ I have no problems bathing or dressing myself ○ I have slight problems bathing or dressing myself ○ I have moderate problems bathing or dressing myself ○ I have severe problems bathing or dressing myself ○ I am unable to bathe or dress myself ○ Not Done
Usual Activities (e.g.work,study, housework,family or leisure activities)	○ I have no problems doing my usual activities ○ I have slight problems doing my usual activities ○ I have moderate problems doing my usual activities ○ I have severe problems doing my usual activities ○ I am unable to do my usual activities ○ Not Done
Pain/Discomfort	○ I have no pain or discomfort ○ I have slight pain or discomfort ○ I have moderate pain or discomfort ○ I have severe pain or discomfort ○ I have extreme pain or discomfort ○ Not Done
Anxiety/Depression	○ I am not anxious or depressed ○ I am slightly anxious or depressed ○ I am moderately anxious or depressed ○ I am severely anxious or depressed ○ I am extremely anxious or depressed ○ Not Done
Your Health Today	_____

FACT-OSI	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
I Have a Lack of Energy	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Been Vomiting	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I have Pain	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Nausea	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Swelling in my Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I worry that my condition Will Get Worse	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I am content with the quality of My Life Right now	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Cramps in My Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done

SHR-A1811 PK Sample collection	
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

SHR169265 PK Sample Collection	
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

SHR-A1811 ADA Sample Collection	
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

End of SHR-A1811 Treatment	
Study Treatment	● SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
Discontinuation Date	_____
Primary Reason for Discontinuation	○ Clinical Progression ○ Imaging Progression ○ Adverse Event ○ Lost to Follow-up ○ Death ○ Treatment Terminated by Subject ○ Physician Decision ○ Protocol Deviation ○ Study Terminated by Sponsor ○ Pregnancy ○ Other
Specify	_____

End of Doxorubicin HydrochlorideTreatment	
Study Treatment	○ SHR-A1811 ● Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ○ Gemcitabine
Discontinuation Date	_____
Primary Reason for Discontinuation	○ Clinical Progression ○ Imaging Progression ○ Adverse Event ○ Lost to Follow-up ○ Death ○ Treatment Terminated by Subject ○ Physician Decision ○ Protocol Deviation ○ Study Terminated by Sponsor ○ Pregnancy ○ Other
Specify	_____

End of Paclitaxel Treatment	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ● Paclitaxel ○ Topotecan ○ Gemcitabine
Discontinuation Date	_____
Primary Reason for Discontinuation	○ Clinical Progression ○ Imaging Progression ○ Adverse Event ○ Lost to Follow-up ○ Death ○ Treatment Terminated by Subject ○ Physician Decision ○ Protocol Deviation ○ Study Terminated by Sponsor ○ Pregnancy ○ Other
Specify	_____

End of Topotecan Treatment	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ● Topotecan ○ Gemcitabine
Discontinuation Date	_____
Primary Reason for Discontinuation	○ Clinical Progression ○ Imaging Progression ○ Adverse Event ○ Lost to Follow-up ○ Death ○ Treatment Terminated by Subject ○ Physician Decision ○ Protocol Deviation ○ Study Terminated by Sponsor ○ Pregnancy ○ Other
Specify	_____

End of Gemcitabine Treatment	
Study Treatment	○ SHR-A1811 ○ Doxorubicin Hydrochloride ○ Paclitaxel ○ Topotecan ● Gemcitabine
Discontinuation Date	_____
Primary Reason for Discontinuation	○ Clinical Progression ○ Imaging Progression ○ Adverse Event ○ Lost to Follow-up ○ Death ○ Treatment Terminated by Subject ○ Physician Decision ○ Protocol Deviation ○ Study Terminated by Sponsor ○ Pregnancy ○ Other
Specify	_____

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Erythrocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Hemoglobin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Platelets			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Erythrocytes_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Occult Blood_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

EQ-5D-5L	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
Mobility	○ I have no problems in walking ○ I have slight problems in walking ○ I have moderate problems in walking ○ I have severe problems in walking ○ I am unable to walk ○ Not Done
Self-care	○ I have no problems bathing or dressing myself ○ I have slight problems bathing or dressing myself ○ I have moderate problems bathing or dressing myself ○ I have severe problems bathing or dressing myself ○ I am unable to bathe or dress myself ○ Not Done
Usual Activities (e.g.work,study, housework,family or leisure activities)	○ I have no problems doing my usual activities ○ I have slight problems doing my usual activities ○ I have moderate problems doing my usual activities ○ I have severe problems doing my usual activities ○ I am unable to do my usual activities ○ Not Done
Pain/Discomfort	○ I have no pain or discomfort ○ I have slight pain or discomfort ○ I have moderate pain or discomfort ○ I have severe pain or discomfort ○ I have extreme pain or discomfort ○ Not Done
Anxiety/Depression	○ I am not anxious or depressed ○ I am slightly anxious or depressed ○ I am moderately anxious or depressed ○ I am severely anxious or depressed ○ I am extremely anxious or depressed ○ Not Done
Your Health Today	_____

FACT-OSI	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
I Have a Lack of Energy	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Been Vomiting	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I have Pain	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Nausea	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Swelling in my Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I worry that my condition Will Get Worse	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I am content with the quality of My Life Right now	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Cramps in My Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done

SHR-A1811 ADA Sample Collection	
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

Survival Follow-up	
Date of Contact	_____
Survival Status	○ Alive ○ Dead ○ Lost to Follow-up

Tumor Marker

Visit	○ Screening ○ Week 6 ○ Week 12 ○ Week 18 ○ Week 24 ○ Week 30 ○ Week 36 ○ Week 48 ○ Week 60 ○ Week 72 ○ Week 84 ○ Week 96 ○ Week 108 ○ Week 120 ○ Week 132 ○ Week 144 ○ Week 156 ○ Week 168 ○ Week 180 ○ Week 192 ○ End of Treatment ○ Unplanned Visit 1 ○ Unplanned Visit 2 ○ Unplanned Visit 3 ○ Unplanned Visit 4 ○ Unplanned Visit 5
Collection Date	_____
LAB Name	_____

Laboratory Detail

#	Test Name	Result	Unit	Reference value - lower limit	Reference value - upper limit
1	CA-125				

Tumor Imaging	
Visit	○ Screening ○ Week 6 ○ Week 12 ○ Week 18 ○ Week 24 ○ Week 30 ○ Week 36 ○ Week 48 ○ Week 60 ○ Week 72 ○ Week 84 ○ Week 96 ○ Week 108 ○ Week 120 ○ Week 132 ○ Week 144 ○ Week 156 ○ Week 168 ○ Week 180 ○ Week 192 ○ End of Treatment ○ Unplanned Visit 1 ○ Unplanned Visit 2 ○ Unplanned Visit 3 ○ Unplanned Visit 4 ○ Unplanned Visit 5
Method	○ CT Scan without Contrast ○ Contrast Enhanced CT Scan ○ MRI without Contrast ○ Contrast Enhanced MRI ○ Bone Scan ○ PET-CT ○ Other
Other, Specify	_____
Exam/Scan Date	_____
Was the scan taken at the study site?	○ Yes ○ No

Target Lesion	
Anatomical Location	○ Brain ○ Esophagus ○ Stomach ○ Small Intestine ○ Colon ○ Rectum ○ Liver ○ Gallbladder ○ Bile Duct ○ Pancreas ○ Lung ○ Trachea ○ Breast ○ Ovary ○ Fallopian Tube ○ Uterus ○ Cervix Uteri ○ Vagina ○ Kidney ○ Ureter ○ Bladder ○ Urethra ○ Thyroid Gland ○ Adrenal Gland ○ Spleen ○ Lymph Node ○ Pericardium ○ Pleura ○ Peritoneum ○ Pericardial Effusion ○ Pleural Effusion ○ Peritoneal Effusion ○ Bone ○ Soft Tissue ○ Skin ○ Other
Other, Specify	_____
Location Detail	_____

Target Lesion Detail						
#	Visit	Was the assessment performed?	Tumor Imaging ID	Diameter	Unit	If not measured accurately, please provide the reason

	○ Screening ○ Week 6 ○ Week 12 ○ Week 18 ○ Week 24 ○ Week 30 ○ Week 36 ○ Week 48 ○ Week 60 ○ Week 72 ○ Week 84 ○ Week 96 ○ Week 108 ○ Week 120 ○ Week 132 ○ Week 144 ○ Week 156 ○ Week 168 ○ Week 180 ○ Week 192 ○ End of Treatment ○ Unplanned Visit 1 ○ Unplanned Visit 2 ○ Unplanned Visit 3 ○ Unplanned Visit 4 ○ Unplanned Visit 5	○ Yes ○ No			● mm	○ Too Small to Measure ○ Equivocal

Non-target Lesion	
Anatomical Location	○ Brain ○ Esophagus ○ Stomach ○ Small Intestine ○ Colon ○ Rectum ○ Liver ○ Gallbladder ○ Bile Duct ○ Pancreas ○ Lung ○ Trachea ○ Breast ○ Ovary ○ Fallopian Tube ○ Uterus ○ Cervix Uteri ○ Vagina ○ Kidney ○ Ureter ○ Bladder ○ Urethra ○ Thyroid Gland ○ Adrenal Gland ○ Spleen ○ Lymph Node ○ Pericardium ○ Pleura ○ Peritoneum ○ Pericardial Effusion ○ Pleural Effusion ○ Peritoneal Effusion ○ Bone ○ Soft Tissue ○ Skin ○ Other
Other, Specify	_____
Location Detail	_____

Non-target Lesion Detail				
#	Visit	Was the assessment performed?	Tumor Imaging ID	Lesion Status

	○ Screening ○ Week 6 ○ Week 12 ○ Week 18 ○ Week 24 ○ Week 30 ○ Week 36 ○ Week 48 ○ Week 60 ○ Week 72 ○ Week 84 ○ Week 96 ○ Week 108 ○ Week 120 ○ Week 132 ○ Week 144 ○ Week 156 ○ Week 168 ○ Week 180 ○ Week 192 ○ End of Treatment ○ Unplanned Visit 1 ○ Unplanned Visit 2 ○ Unplanned Visit 3 ○ Unplanned Visit 4 ○ Unplanned Visit 5	○ Yes ○ No		○ Present ○ Absent ○ Unequivocal Progression ○ Equivocal

New Lesion	
Anatomical Location	○ Brain ○ Esophagus ○ Stomach ○ Small Intestine ○ Colon ○ Rectum ○ Liver ○ Gallbladder ○ Bile Duct ○ Pancreas ○ Lung ○ Trachea ○ Breast ○ Ovary ○ Fallopian Tube ○ Uterus ○ Cervix Uteri ○ Vagina ○ Kidney ○ Ureter ○ Bladder ○ Urethra ○ Thyroid Gland ○ Adrenal Gland ○ Spleen ○ Lymph Node ○ Pericardium ○ Pleura ○ Peritoneum ○ Pericardial Effusion ○ Pleural Effusion ○ Peritoneal Effusion ○ Bone ○ Soft Tissue ○ Skin ○ Other
Other, Specify	_____
Location Detail	_____

New Lesion Detail			
#	Visit	Was the assessment performed?	Tumor Imaging ID

	○ Week 6 ○ Week 12 ○ Week 18 ○ Week 24 ○ Week 30 ○ Week 36 ○ Week 48 ○ Week 60 ○ Week 72 ○ Week 84 ○ Week 96 ○ Week 108 ○ Week 120 ○ Week 132 ○ Week 144 ○ Week 156 ○ Week 168 ○ Week 180 ○ Week 192 ○ End of Treatment ○ Unplanned Visit 1 ○ Unplanned Visit 2 ○ Unplanned Visit 3 ○ Unplanned Visit 4 ○ Unplanned Visit 5	○ Yes ○ No	

Response Assessment	
Visit	○ Week 6 ○ Week 12 ○ Week 18 ○ Week 24 ○ Week 30 ○ Week 36 ○ Week 48 ○ Week 60 ○ Week 72 ○ Week 84 ○ Week 96 ○ Week 108 ○ Week 120 ○ Week 132 ○ Week 144 ○ Week 156 ○ Week 168 ○ Week 180 ○ Week 192 ○ End of Treatment ○ Unplanned Visit 1 ○ Unplanned Visit 2 ○ Unplanned Visit 3 ○ Unplanned Visit 4 ○ Unplanned Visit 5
Was response assessment performed?	○ Yes ○ No
If not, provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
Target Response	○ NED ○ CR ○ PR ○ SD ○ PD ○ NE
Non-target Response	○ NED ○ CR ○ Non-CR/Non-PD ○ PD ○ NE
Any new lesion?	○ Yes ○ No
Overall Response	○ NED ○ CR ○ PR ○ SD ○ Non-CR/Non-PD ○ PD ○ NE

Adverse Event	
Adverse Event	_____
Start Date	_____
Outcome	○ Fatal ○ Not Recovered/Not Resolved ○ Recovered/Resolved ○ Recovered/Resolved with Sequelae ○ Recovering/Resolving ○ Unknown
End Date	_____
Action Taken with SHR-A1811	○ Dose Not Changed ○ Drug Interrupted ○ Dose Reduced ○ Drug Withdrawn ○ Not Applicable
Action Taken with Doxorubicin Hydrochloride	○ Dose Not Changed ○ Drug Interrupted ○ Dose Reduced ○ Drug Withdrawn ○ Not Applicable
Action Taken with Paclitaxel	○ Dose Not Changed ○ Drug Interrupted ○ Dose Reduced ○ Drug Withdrawn ○ Not Applicable
Action Taken with Topotecan	○ Dose Not Changed ○ Drug Interrupted ○ Dose Reduced ○ Drug Withdrawn ○ Not Applicable
Action Taken with Gemcitabine	○ Dose Not Changed ○ Drug Interrupted ○ Dose Reduced ○ Drug Withdrawn ○ Not Applicable
CTCAE Grade	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
Was any treatment given for AE?	○ Yes ○ No

Relationship to SHR-A1811	○ Definitely Related ○ Probably Related ○ Possibly Related ○ Unlikely Related ○ Unrelated
Relationship to Doxorubicin Hydrochloride	○ Definitely Related ○ Probably Related ○ Possibly Related ○ Unlikely Related ○ Unrelated
Relationship to Paclitaxel	○ Definitely Related ○ Probably Related ○ Possibly Related ○ Unlikely Related ○ Unrelated
Relationship to Topotecan	○ Definitely Related ○ Probably Related ○ Possibly Related ○ Unlikely Related ○ Unrelated
Relationship to Gemcitabine	○ Definitely Related ○ Probably Related ○ Possibly Related ○ Unlikely Related ○ Unrelated
Is this event of special interest?	○ Yes ○ No
Was the adverse event serious?	○ Yes ○ No
Results in Death	○ Yes ○ No
Is Life Threatening	○ Yes ○ No
Requires or Prolongs Hospitalization	○ Yes ○ No
Persist or Significant Disability/Incapacity	○ Yes ○ No
Congenital Anomaly or Birth Defect	○ Yes ○ No
Other Medically Important Serious Event	○ Yes ○ No
Other Medically Important Serious Event, Specify	_____

Infusion Related Reaction	
Adverse Event Identifier	_____
Symptom	☐ Fever ☐ Chills ☐ Rigors ☐ Headache ☐ Rash ☐ Pruritus ☐ Joint Pain ☐ Low Blood Pressure ☐ High Blood Pressure ☐ Bronchospasm ☐ Other
Other, Specify	_____
CTCAE Grade	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
Start Date	_____
Start Time	_____
Ongoing	○ Yes ○ No
End Date	_____
End Time	_____

Prior and Concomitant Medication	
Medication Name	_____
Start Date	_____
Ongoing	○ Yes ○ No
End Date	_____
Indication	○ Adverse Event ○ Medical History ○ Other
Other, Specify	_____
Indication Description	_____
Adverse Event Identifier	_____
Medical History Identifier	_____
Dose	_____
Unit	○ mg ○ ug ○ mL ○ g ○ IU ○ mg/kg ○ mg/m2 ○ Tablet ○ Capsule ○ Inhalation ○ Drop ○ Other
Other Unit, Specify	_____
Dose Form	○ Tablet ○ Capsule ○ Ointment ○ Spray ○ Powder-injection ○ Injection ○ Suspension ○ Suppository ○ Powder ○ Granule ○ Dripping Pill ○ Liquid ○ Cream ○ Other

Other Dose Form, Specify	_____
Route	○ Oral (PO) ○ Topical (TO) ○ Subcutaneous (SC) ○ Transdermal (DE) ○ Intraocular ○ Intramuscular (IM) ○ Respiratory (Inhalation) ○ Intralesional ○ Intraperitoneal ○ Nasal (IN) ○ Vaginal ○ Rectal ○ Sublingual (SL) ○ Intravenous ○ Intra-articular ○ Pharyngeal ○ Auricular(OTIC) ○ Oromucosal ○ Intrauterine ○ Nasogastric ○ Other
Other Route, Specify	_____
Frequency	○ Daily (QD) ○ Twice Daily (BID) ○ Three Times Daily (TID) ○ Four Times Daily (QID) ○ Every night ○ Every Other Day (QOD) ○ Once Weekly (QS) ○ Twice Weekly (BIS) ○ Three Times Weekly (TIS) ○ Four Times Weekly (QIS) ○ Every 2 Weeks (Q2S) ○ Every 3 Weeks (Q3S) ○ Every 4 Weeks (Q4S) ○ Monthly (QM) ○ ONCE ○ As Needed (PRN) ○ Other
Other Frequency, Specify	_____

Protocol Deviation	
Protocol Deviation Number	_____
Date Deviation First Noted	_____
Event Description	○ Used un-approved version of protocol (approval by EC/Local Regulatory Authority) ○ Study procedure(s) conducted prior to subject Informed Consent process ○ Incorrect version of written Informed Consent Form used ○ Subject Enrolled in error ○ Subject Randomized in error ○ Protocol specified Visit not performed ○ Protocol specified procedure not performed ○ Error in Protocol specified procedure ○ Protocol specified Procedure/Assessment performed outside acceptable window ○ Study Visit performed outside acceptable window ○ Noncompliance with respect to handling and/or use of study medication/study device ○ Subject non-compliance with study procedures ○ Subject non-compliance with study drug ○ Delay in reporting of immediately reportable SAE ○ Use of prohibited medication/therapy ○ Unscheduled unblinding of study participant ○ Other
Specify Details	_____
Visit Number	_____
Action Taken by Investigator	_____
Is any impact expected on subject's safety due to this protocol deviation?	○ Yes ○ No

Prior and Concomitant Procedure	
Procedure Name	_____
Start Date	_____
Ongoing	○ Yes ○ No
End Date	_____
Indication	○ Adverse Event ○ Medical History ○ Other
Other, Specify	_____
Indication Description	_____
Adverse Event Identifier	_____
Medical History Identifier	_____

Follow-up Cancer Systemic Therapy	
Treatment Setting	○ Adjuvant ○ Advanced/Metastatic ○ Maintenance
Line of Therapy	○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ >6
Other Line,Specify	_____
Regimen (s)	_____
Number of Treatment Cycle (s)	_____
Date of Progressive Disease	_____

Follow-up Cancer Systemic Therapy Detail

#	Medication Name	Type of Treatment	Other Type, Specify	Dose	Unit	Other Unit, Specify	Frequency	Other Frequency, Specify	Start Date	Ongoing	End Date

		○ Chemotherapy ○ Endocrine Therapy ○ Immunotherapy ○ PARP Inhibitors ○ Anti-HER2 Targeted Therapy ○ Anti-VEGF/VEGFR Targeted Therapy ○ Targeted Therapy ○ Other			○ mg ○ ug ○ mL ○ g ○ IU ○ mg/kg ○ mg/m2 ○ Tablet ○ Capsule ○ Inhalation ○ Drop ○ Other		○ Daily (QD) ○ Twice Daily (BID) ○ Three Times Daily (TID) ○ Four Times Daily (QID) ○ Every night ○ Every Other Day (QOD) ○ Once Weekly (QS) ○ Twice Weekly (BIS) ○ Three Times Weekly (TIS) ○ Four Times Weekly (QIS) ○ Every 2 Weeks (Q2S) ○ Every 3 Weeks (Q3S) ○ Every 4 Weeks (Q4S) ○ Monthly (QM) ○ ONCE ○ As Needed (PRN) ○ Other			○ Yes ○ No	

Follow-up Cancer Radiotherapy	
Location	☐ Brain ☐ Esophagus ☐ Stomach ☐ Small Intestine ☐ Colon ☐ Rectum ☐ Liver ☐ Gallbladder ☐ Bile Duct ☐ Pancreas ☐ Lung ☐ Trachea ☐ Breast ☐ Ovary ☐ Fallopian Tube Uterus ☐ Cervix Uteri ☐ Vagina ☐ Kidney ☐ Ureter ☐ Bladder ☐ Urethra ☐ Thyroid Gland ☐ Adrenal Gland ☐ Spleen ☐ Lymph Node ☐ Pericardium ☐ Pleura ☐ Peritoneum ☐ Pericardial Effusion ☐ Pleural Effusion ☐ Peritoneal Effusion ☐ Bone ☐ Soft Tissue ☐ Skin ☐ Other
Other Location, Specify	_____
Radiotherapy on Target Lesions	○ Yes ○ No
Start Date	_____
Ongoing	○ Yes ○ No
End Date	_____
Total Dose	_____
Unit	○ cGy ○ Gy
Intent of Radiotherapy	○ Curative ○ Palliative ○ Other
Other Intent, Specify	_____

Follow-up Cancer Surgery	
Surgery Name	_____
Surgery Date	_____
Intent of Surgery	○ Diagnostic ○ Curative ○ Palliative ○ Other
Other Intent, Specify	_____
Location	☐ Brain ☐ Esophagus ☐ Stomach ☐ Small Intestine ☐ Colon ☐ Rectum ☐ Liver ☐ Gallbladder ☐ Bile Duct ☐ Pancreas ☐ Lung ☐ Trachea ☐ Breast ☐ Ovary ☐ Fallopian Tube ☐ Uterus ☐ Cervix Uteri ☐ Vagina ☐ Kidney ☐ Ureter ☐ Bladder ☐ Urethra ☐ Urethra ☐ Thyroid Gland ☐ Adrenal Gland ☐ Spleen ☐ Lymph Node ☐ Pericardium ☐ Pleura ☐ Peritoneum ☐ Pericardial Effusion ☐ Pleural Effusion ☐ Peritoneal Effusion ☐ Bone ☐ Soft Tissue ☐ Skin ☐ Other
Other Location, Specify	_____

Follow-up Locoregional Therapy	
Category of Treatment	○ Transarterial Chemoembolization (TACE) ○ Transhepatic Arterial Infusion (TAI) ○ Transarterial Embolization (TAE) ○ Radiofrequency Ablation (RFA) ○ Microwave Ablation (MWA) ○ Percutaneous Ethanol Injection (PEI) ○ Cryoablation (CRA) ○ High Power Focused Ultrasound Ablation (HIFU) ○ Radioactive Seed Implantation ○ Hyperthermic Peritoneal Perfusion(CHPP) ○ Hyperthermic Intraperitoneal Peroperative Chemotherapy(HIPEC) ○ Other
Other, Specify	_____
Start Date	_____
End Date	_____
Response Assessment	○ CR ○ PR ○ SD ○ Non-CR/Non-PD ○ PD ○ NE
Ablation Response	○ Complete Response ○ Incomplete Response ○ Unknown
Was Any Medication Taken?	○ Yes ○ No

Follow-up Locoregional Therapy Detail	
#	Medication Name

Biomarker Collection	
Was the Specimen Collected?	○ Yes ○ No
Test Name	□ HER2 Test □ FISH Test
Collection Date	_____
Specimen Type	○ Fresh Biopsy ○ Archived Tissue
Pre-Screen ID	_____

Physical Examination

Exam Date

_____

Physical Examination Detail

#	Body System	Result	Abnormal Findings
1	General Status	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
2	Head and Face	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
3	Skin	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
4	Lymph Node	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
5	Eyes	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
6	Ears	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
7	Nose	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
8	Throat	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
9	Oral Cavity	○ Normal ○ Abnormal, Not Clinically Significant	

		○ Abnormal, Clinically Significant	
10	Respiratory System	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
11	Cardiovascular System	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
12	Abdomen	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
13	Urogenital System	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
14	Musculoskeletal	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
15	Neurological	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	
16	Mental Status	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant	

Weight	
Exam Date	_____
Weight	_____
Unit	● kg

Vital Signs

Exam Date _____

Vital Signs Detail

#	Test Name	Result	Unit	Interpretation
1	Temperature		℃	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
2	Pulse Rate		beats/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
3	Respiratory Rate		breaths/min	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
4	Systolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
5	Diastolic Blood Pressure		mmHg	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant

ECOG Performance Status	
Assessment Date	_____
Result	○ 0-Fully active, able to carry on all pre-disease performance without restriction ○ 1-Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work ○ 2-Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours ○ 3-Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours ○ 4-Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair ○ 5-Dead

Electrocardiogram	
Exam Date	_____
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

12-lead Electrocardiogram Detail

#	Test Name	Result	Unit
1	Heart Rate		beats/min
2	PR		ms
3	QT		ms
4	QTcF		ms

Hematology						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Absolute Neutrophil Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Absolute Lymphocyte Count			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Erythrocytes			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Hemoglobin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Platelets			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Chemistry						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Albumin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Alkaline Phosphatase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Alanine Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	Aspartate Aminotransferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
7	Gamma Glutamyl Transferase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
8	Direct Bilirubin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
9	Triglycerides			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

10	Cholesterol			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
11	Urea			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
12	Urea nitrogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
13	Creatinine			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
14	Urate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

15	Potassium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
16	Sodium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
17	Chloride			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
18	Calcium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
19	Magnesium			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

20	Phosphate			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
21	Lactate Dehydrogenase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
22	Fasting Plasma Glucose			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Amylase and Lipase

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Amylase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Lipase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Urinalysis

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Leukocytes_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Protein_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Erythrocytes_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Occult Blood_U			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Stool Analysis

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Fecal Occult Blood			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Coagulation

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Prothrombin Time (PT)			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	International Normalized Ratio (INR)			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Activated Partial Thromboplastin Time (APTT)			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Fibrinogen			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	D-Dimer			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Thyroid Function

Collection Date _____

LAB Name _____

Laboratory Detail

#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Triiodothyronine, Free			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Thyroxine, Free			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Thyrotropin			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Myocardial Zymogram						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Creatine Kinase			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
2	Creatine Kinase MB			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
3	Troponin I			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
4	Troponin T			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

5	ProB-type Natriuretic Peptide			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		
6	Brain Natriuretic Peptide			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

U24Protein						
Collection Date _____						
LAB Name _____						
Laboratory Detail						
#	Test Name	Result	Unit	Clinical Significance	Reference value - lower limit	Reference value - upper limit
1	Protein_U24			○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant		

Pregnancy Test	
Collection Date	_____
Result	○ Negative ○ Positive

Echocardiography	
Exam Date	_____
LVEF	_____
Unit	● %
Clinical Significance	○ Normal ○ Abnormal, Not Clinically Significant ○ Abnormal, Clinically Significant
Abnormal, Specify	_____

EQ-5D-5L	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
Mobility	○ I have no problems in walking ○ I have slight problems in walking ○ I have moderate problems in walking ○ I have severe problems in walking ○ I am unable to walk ○ Not Done
Self-care	○ I have no problems bathing or dressing myself ○ I have slight problems bathing or dressing myself ○ I have moderate problems bathing or dressing myself ○ I have severe problems bathing or dressing myself ○ I am unable to bathe or dress myself ○ Not Done
Usual Activities (e.g.work,study, housework,family or leisure activities)	○ I have no problems doing my usual activities ○ I have slight problems doing my usual activities ○ I have moderate problems doing my usual activities ○ I have severe problems doing my usual activities ○ I am unable to do my usual activities ○ Not Done
Pain/Discomfort	○ I have no pain or discomfort ○ I have slight pain or discomfort ○ I have moderate pain or discomfort ○ I have severe pain or discomfort ○ I have extreme pain or discomfort ○ Not Done
Anxiety/Depression	○ I am not anxious or depressed ○ I am slightly anxious or depressed ○ I am moderately anxious or depressed ○ I am severely anxious or depressed ○ I am extremely anxious or depressed ○ Not Done
Your Health Today	_____

FACT-OSI	
Was the assessment performed?	○ Yes ○ No
If no, please provide the reason	○ Adverse Event ○ Other
Other, Specify	_____
If yes, was it done on site or remotely?	○ On Site ○ Remotely
Assessment Date	_____
I Have a Lack of Energy	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Been Vomiting	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I have Pain	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Nausea	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Swelling in my Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I worry that my condition Will Get Worse	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I am content with the quality of My Life Right now	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done
I Have Cramps in My Stomach Area	○ Not at All ○ A Little bit ○ Somewhat ○ Quite a Bit ○ Very Much ○ Not Done

SHR-A1811 PK Sample collection	
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

SHR169265 PK Sample Collection	
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

SHR-A1811 ADA Sample Collection	
Was the sample collected?	○ Yes ○ No
Reason Not Collected	○ Adverse Event ○ Other
Other, Specify	_____
Collection Date	_____
Collection Time	_____

Pregnancy Report	
Date of Last Menstrual Period	_____
Outcome of Pregnancy	○ Pregnancy Ongoing ○ Normal Delivery ○ Spontaneous Abortion ○ Induced Abortion-Social Reason ○ Induced Abortion-Foetal Anomaly ○ Premature Birth ○ Stillbirth ○ Birth Defect ○ Ectopic Pregnancy ○ Lost to Follow-up ○ Unknown
Date of Delivery/Termination	_____
Please Specify the Foetal Anomaly	_____
Was the adverse event serious?	○ Yes ○ No

End of Follow-up	
End of Follow-up Date	_____
End of Follow-up Reason	○ Lost to Follow-up ○ Death ○ Withdrawal by Subject ○ Physician Decision ○ Study Terminated by Sponsor ○ Other
Specify	_____
Primary Cause of Death	○ Progressive Disease ○ Adverse Event ○ Other
Other, Specify	_____
Death Date	_____
Last Known Survival Date	_____