



Study	1378-0041 DEV1
Casebook Definition Name	InitialVersion
Casebook Definition External ID	InitialVersion
Generation Mode	Unique CRFs (No Schedule)
Include Annotations	No
Casebook Version	1.2
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Specification Version	

12-Lead ECG (ECG_01_v001)

12-Lead ECG		
ECG Date		
ECG Time		
(If triplicate ECG was performed, please report the time of last recording.)		: 24 hour clock
Overall Assessment	Normal	
	Abnormal	
	Not Evaluable	
Clinically Significant	No	
	Yes	
Related Event / Condition (Select all that apply)		
Adverse Event		
Please provide a link to corresponding Adverse Event record(s).		
Baseline Condition		
Please provide a link to corresponding Baseline Condition record(s).		
Medical History		
Please provide a link to corresponding Medical History record(s).		

ACTH Testing (ACTH_01)

ACTH Testing	
Was ACTH Stimulation Test performed?	No Yes
Date of Test	
Cortisol Level at time zero	mcg/dL nmol/L
Cortisol Level at time 1 (e.g. after 30 minutes)	mcg/dL nmol/L
Cortisol Level at time 2 (e.g. after 60 minutes)	mcg/dL nmol/L
Specimen Type	Serum Plasma

Adverse Events (AE_01_v003)

Adverse Event	
Adverse Event Select	Potential DILI Cortisol Insufficiency Cortisol Excess Ketoacidosis Acute Kidney Injury Hypotension Hyperkalemia MI (fatal or non-fatal) Stroke (fatal or non-fatal) TIA Heart Failure Hospitalisation Death due to undetermined cause Other CV Hospitalisation Other CV Death None of the above
AE (Specified)	
Please complete Acute Kidney Injury - Adverse Events CRF.	
Please complete Hyperkalemia - Adverse Events CRF.	
Please complete Hypotension - Adverse Events CRF.	
Please complete Cortisol Insufficiency - Adverse Events CRF.	
Please complete Ketoacidosis/Metabolic Acidosis - Adverse Events CRF.	
Adverse Event <i>(If a pre-existing condition (indication or concomitant disease) worsens upon a change in trial phase, it should be recorded as an event with "worsening of" the respective condition. Onset date is the date of exacerbation.)</i>	
Value calculated by the system	

If a coding query is displayed here, please update 'AE Other' as appropriate	
Primary CASE ID	Value calculated by the system
Linked to CASE ID	Value calculated by the system
Start Date (Date when sign(s) and/or symptom(s) of the event were first detected. Onset date of cancer is the date of diagnosis.)	
End Date (For fatal events, the end date is the date of death. Leave the end date blank for events which were present when a subject dies, but which were not the cause of death. Recovered/Resolved with Sequelae is the date when the investigator judged the event as stabilized.)	
Outcome (Resolved With Sequelae: Subject has residual and possibly permanent impairment of health. Indicate unknown, if adverse events are present at the time of death, but are not the main cause of death.)	Recovered/Resolved Not Recovered/Not Resolved Recovered/Resolved With Sequelae Fatal Unknown
Please complete Death - Adverse Events CRF.	
Therapy for Event (The subject was treated due to the adverse event.)	No Yes
Severity/Intensity (An event which worsens after the subject begins treatment or an event which starts during one treatment and worsens during another, must be entered as a new adverse event. Enter date of worsening as both the start date of the new event as well as the end date of the previous event. Previous event outcome will be "Not Recovered/Not Resolved".)	Mild Moderate Severe

Action Taken With Study Treatment Due to AE (Dose not changed also applies to subjects who temporarily discontinued or changed the dose due to an AE and the treatment was re-introduced at the same dose. For events where subject died, report as not applicable.)	Dose Not Changed Dose Reduced Dose Increased Drug Withdrawn Not Applicable
Relationship to Study Treatment (For events occurring during a screening period prior to study drug administration, select "No".)	No Yes
Serious (The event met the criteria for seriousness. Please remember that BI has a defined list of AEs that are considered as 'always serious'.)	No Yes
Death	
Life Threatening	
Disability or Permanent Damage	
Hospitalization (Initial or Prolonged) (Hospitalization includes an admission as a result of an event. Subject treated in the emergency room and released should be evaluated for other serious criteria.)	
Congenital Anomaly or Birth Defect	
Other Serious (Important Medical Events) (Important medical event classified as serious based on medical judgment and/or may require intervention to prevent the event from meeting a serious criterion.)	
Adverse Event of Special Interest	No Yes
If the event does not meet criteria for a new Safety Case or Linked Event, leave the 'Safety Case' field blank.	

Safety Case	New Safety Case
	Linked to Existing Safety Case
	Case to be Nullified
Please link this AE to the Primary event within a case. Use the Case ID to identify the reference number of the Primary event.	
Please complete the following sections below:	
Safety Case - Additional Information.	
Safety Case - Description of Events. Provide a brief narrative description of SAE, autopsy results if any, possible other causes of the event (e.g. lack of efficacy, withdrawal of study treatment(s), the disease under study or other medical conditions) and details of the treatment.	
'Case to be Nullified' must only be selected if all events in this case (including linked events) do not meet the requirement for safety reporting.	
If Nullification of the existing case confirmed, please:	
Complete the section Nullification below. Provide a reason for nullification including details.	
For each event linked to existing case, re-assess the 'Safety Case' field on the respective AE form. If one of these events still requires safety reporting, select 'New Safety Case' or link it to another Safety Case.	

Safety Case - Additional Information	
Height	Value calculated by the system
Weight	(xxxx.y) kg
Pregnant at Time of Event	No
	Yes
If Yes, Number of Weeks	

Safety Case - Description of Events

General Narrative Comment

(Provide additional information relevant to the adverse event which is not captured in the formatted fields of the AE form such as clinical course of the patient, alternative causes for the AE, relevant laboratory values, additional information leading to diagnosis, suspect concomitant medications, rationale for causality assessment with study drug and treatment details)

Safety Case - Linked Adverse Events

Linked Adverse Event

Safety Case - Nullification

Nullification Reason

Events in this Case do not Meet
Requirements for Safety Reporting

Case Entered In Error

Other

Specify

Adverse Events - Acute Kidney Injury (AKI_AE_01)

Acute Kidney Injury - Adverse Event	
Adverse Event Name	
Was the event based on central laboratory values?	No Yes
Date of measurement	
Was a local laboratory value basis for the diagnosis?	No Yes
Date of measurement	
If Local laboratory, please enter the creatinine value	mg/dL umol/L
Potential causal / contributing factors (Respond to all)	
Sepsis or other severe infection (report as separate AE)	No Yes
Circulatory failure (e.g., acute heart failure, shock) (report as separate AE)	No Yes
Volume depletion (e.g. due to diuretics, heat, GI loss, low fluids intake) (report as separate AE)	No Yes
Major trauma or burn (report as separate AE)	No Yes
Major surgery, including cardiac surgery (report as separate AE)	No Yes

Acute anemia (report as separate AE)	No
	Yes
Urinary tract obstruction (report as separate AE)	No
	Yes
Nephrotoxic drugs other than the IMP (please include on Concomitant Medications)	No
	Yes
Radiocontrast agent	No
	Yes
Poison exposure	No
	Yes
Other	No
	Yes
Other, please specify	
Was renal replacement therapy initiated? If YES, please record on Non-medication or Previous and Concomitant treatments form(s)	No
	Yes
Please provide information on any diagnostic test performed for this event	
Renal biopsy	No
	Yes
Renal biopsy date	

Results	
Imaging (e.g. sonography, CT or MRI)	No
	Yes
Imaging date	
Imaging type	Sonography
	CT
	MRI
	Other
Other, please specify	
Results	

Adverse Events - Cortisol Insufficiency (CORTI_AE_01)

Cortisol Insufficiency - Adverse Events	
Adverse Event Name	
Was cortisol insufficiency symptomatic? If YES, please provide symptoms:	No
	Yes
Weakness	No
	Yes
Fatigue	No
	Yes
Anorexia	No
	Yes
Orthostatic hypotension	No
	Yes
Gastrointestinal symptoms	No
	Yes
Adrenal crisis	No
	Yes
Other	No
	Yes
Other, please specify	

Please indicate how Cortisol Insufficiency was diagnosed.	
Based on morning cortisol	No
	Yes
Link to Cortisol Measurement	
Was diagnose confirmed by a second test result?	No
	Yes
Link to Cortisol Measurement	
Based on abnormal ACTH stimulation test	No
	Yes
	Not performed
Link to ACTH Testing	
Based on Other	No
	Yes
Other, please specify	
Was glucocorticoid replacement therapy initiated?	No
	Yes
Link to Therapy	

Adverse Events - Death (DEATH_AE_01)

Death - Adverse Events	
Adverse Event Name	
Date of Death	
Primary Cause of Death	CV Death
	Non CV Death
	Undetermined Cause of Death
If CV please specify	Sudden Cardiac Death
	Acute Myocardial Infarction
	Heart Failure
	Stroke
	Cardiovascular Procedures
	Cardiovascular Haemorrhage
	Other Cardiovascular Causes

If non-CV:

Renal death (please click on question mark for protocol definition)

Pulmonary

Gastrointestinal

Hepatobiliary

Pancreatic

Infection (includes sepsis)

Inflammatory (e.g., Systemic Inflammatory Response Syndrome (SIRS) / Immune (including autoimmune) (may include anaphylaxis from environmental (e.g. food) allergies)

Haemorrhage that is neither CV bleeding or a stroke

Non-CV procedure or surgery

Trauma

Suicide

Non-prescription drug reaction or overdose

Prescription drug reaction or overdose (may include anaphylaxis)

Neurological (non-CV)

Malignancy

Other non-CV causes

Adverse Events - Hyperkalemia (HK_AE_01)

Hyperkalemia - Adverse Events	
Adverse Event Name	
Highest potassium level during episode	Millimoles per liter Milliequivalents per liter
Was hyperkalemia episode actively treated? (If Yes, respond to all)	No Yes
Hemodialysis	No Yes
Other	No Yes
Other, please specify	
Was this episode of hyperkalemia symptomatic? (If Yes, respond to all)	No Yes
Muscle weakness	No Yes
Flaccid paralysis	No Yes
Frank paralysis	No Yes
Cardiac arrhythmias	No Yes

Other	No
	Yes
Other, please specify	
Pre-existing conditions (Respond to all)	
Acute kidney injury (report as separate AE)	No
	Yes
Metabolic acidosis (report as separate AE)	No
	Yes
Rhabdomyolysis, or major trauma or burn (report as separate AE)	No
	Yes
Strenuous exercise	No
	Yes
Hyperglycemia or insulin deficiency (report as separate AE or con meds if applicable)	No
	Yes
Dose increase / addition of potassium supplement, potassium sparing diuretics, ACEi or ARB (report in con med page, if applicable)	No
	Yes
Dose increase / addition of non-selective beta-blocker (report in con med page, if applicable)	No
	Yes
Radiotherapy	No
	Yes

Cytotoxic drugs (e.g. chemotherapy)	No
	Yes

Adverse Events - Hypotension (HYPO_AE_01)

Hypotension	
Adverse Event Name	
Was event associated with a change of body position?	No
	Yes
Was event symptomatic?	No
	Yes
Tachycardia	No
	Yes
Dizziness	No
	Yes
Diaphoresis	No
	Yes
Nausea	No
	Yes
Vomiting	No
	Yes
Other	No
	Yes
Other, please specify	

Please provide lowest blood pressure values	
Systolic Blood Pressure	mmHg
Diastolic Blood Pressure	mmHg
Risk factor?	No
	Yes
Heat	No
	Yes
Vomiting	No
	Yes
Diarrhea	No
	Yes
Reduced fluids intake	No
	Yes
Alcohol use	No
	Yes
Antihypertensive therapy increased	No
	Yes
Other	No
	Yes

Other, please specify	
Actions taken?	No
	Yes
Sitting/lying down	No
	Yes
Fluids intake increased	No
	Yes
Antihypertensive drugs reduced/modified	No
	Yes
Other action taken	No
	Yes
Other action taken, please specify	

Adverse Events - Ketoacidosis/ Metabolic Acedosis (KAMA_AE_01)

Ketoacidosis/Metabolic Acidosis - Adverse Events	
Adverse Event Name	
Type of metabolic Ketoacidosis	Diabetic Ketoacidosis Starvation Ketoacidosis Unknown Other
Where was the subject treated?	Doctors office/clinic Home ER Other
Laboratory Findings for Metabolic Acidosis:	
Blood pH (Blood Gas Analysis)	Not Measured Less than 7.00 7.00 - 7.24 7.25 - 7.30 Greater than 7.30
Blood Bicarbonate (mEq/L)	Not Measured Less than 10 mEq/L From 10 mEq/L to less than 15 mEq/L 15 mEq/L - 18 mEq/L Greater than 18 mEq/L

Anion Gap (mEq/L)	Not Measured Less than or equal to 10 mEq/L Greater than 10 mEq/L or less than/equal to 12 mEq/L 15 mEq/L - 18 mEq/L Greater than 12 mEq/L
Glucose Value	Milligrams per deciliter Millimoles per litre
Urine ketones (if measured)	Not Measured Small/Trace/Negative Positive (+ or Low) Positive (greater than or equal to moderate; or greater than or equal to ++)
Serum Chloride Value	Milligrams per deciliter Millimoles per liter
Serum Potassium Value (if measured)	Millimoles per Litre
Effective Serum Osmolality (mOsm/kg)	Not Measured Less than or equal to 320 mOsm/kg Greater than 320 mOsm/kg
Was the blood ketone level/blood beta-hydroxybutyrate measured?	No Yes
Highest blood ketone value (related to this event)	Millimoles per Litre

Date of Highest blood ketone value (dd MMM yyyy)	
Was the subject on insulin therapy?	No
	Yes
Please record dose	
Multiple daily injection subjects	
Total bolus dose (IU) during the last 24 hours	
Total basal dose (IU) during the last 24 hours	
Continuous Subcutaneous Insulin Injection subjects	
Total daily dose (IU) during the last 24 hours	
Was there any change in insulin dose prior to this event?	No
	Yes
Was the dose increased or decreased?	Increased
	Decreased
Was the subject on any other anti-hyperglycemic drugs (other than insulin)?	No
	Yes
Was there any change in any of the anti-hyperglycemic drugs (other than insulin) dose prior to this event?	No
	Yes
Select Concomitant Medication	
Was the dose increased or decreased?	
	Increased
	Decreased

By how much?	
Pre-existing conditions (Respond to all)	
Concomitant illness/infection (Report a separate event)	No
	Yes
Missed/reduced insulin doses	No
	Yes
Alcohol intake	No
	Yes
Major Surgery (Report reason for surgery as separate event)	No
	Yes
Major Trauma/Burn (Report a separate event)	No
	Yes
Severe dehydration (Report a separate event)	No
	Yes
Dietary changes/carbohydrate depletion/change in caloric intake	No
	Yes
Other precipitating factors (Report a separate event, if applicable)	No
	Yes
Other, please specify	

Any Signs or Symptoms? (If yes, respond to all)	No
	Yes
Reduced level of consciousness	No
	Yes
Non-Neurological:	
Dehydration	No
	Yes
Tachycardia	No
	Yes
Tachypnoea	No
	Yes
Hypotension	No
	Yes
Hypothermia	No
	Yes
Kussmaul respiration	No
	Yes
Nausea / vomiting	No
	Yes
Abdominal pain	No
	Yes

Adverse Events Confirmation (INCOMP_FORMS_01_v001)

Adverse Events Confirmation	
Has the subject had any adverse events?	No Yes
If Yes, please complete Adverse Events form. Once completed, you will be prompted to RESET this form, perform the RESET and this form will disappear.	

Baseline Conditions / Medical History (BCOND_01_v002)

Baseline Conditions / Medical History	
Study indication should not be entered on this page.	
Condition / Diagnosis <i>(Provide information for chronic diseases (for healthy subjects: clinically relevant chronic diseases), relevant medical conditions, & conditions which may not manifest themselves today (because therapy is given). The study indication should NOT be entered on this form. Signs and symptoms that are part of the normal pattern of a diagnosis should not be entered. The diagnosis alone is sufficient. However, signs and symptoms that are not part of the normal pattern should be entered.)</i>	
Relevant Additional Information <i>(Provide any additional information which is relevant to the condition.)</i>	
Is the condition ongoing after date of Informed Consent?	No
<i>(A condition which is controlled with medication is considered to be ongoing if the condition would manifest itself without the medication. If a condition is controlled with medication, list that medication on the Concomitant Medication form.)</i>	Yes

Clinical Routine Exam (CLINREXAM_1)

Clinical Routine Exam	
Date of Clinical Routine Exam	
Has LVEF been measured?	No
	Yes
EF (%)	
Methodology for EF assessment?	Echocardiography
	Radionuclide Ventriculography
	Ventriculography (Invasive Angiography)
	MRI
	CT-Scan
Which of the following conditions was met for structural heart abnormality?	
LA Width $\geq$ 4.0 cm	
LA Length $\geq$ 5.0 cm	
LA Area $\geq$ 20 cm ²	
LA Volume $\geq$ 55 ml	
LA Volume Index $\geq$ 34 ml/m ²	
Septal Thickness or Posterior Wall Thickness $\geq$ 1.1 cm	
LVMI $\geq$ 115 g/m ² for Males and $\geq$ 95 g/m ² for Females	

Concomitant Medications (CM_03_v001)

Concomitant Medications	
Medication/Drug Therapy (Enter the medication/drug therapy name. For medications, the trade name, if known, should be reported.)	
Was medication started prior to date of informed consent?	No Yes
Start Date	
Medication Ongoing	No Yes
End Date	
Is therapy one of the following: Loop Diuretics, Non-loop diuretics, Other drugs used in Heart Failure, for example, beta-blockers, SGLT2i, ACEi, ARB, sacubitril, ivabradine, cardiac glycoside, hydralazine, nitrates, Other Antihypertensives, Other antidiabetic treatment, Oral Corticosteroids, Amitriptyline, Clomipramine, Fluconazole, Methotrexate, Phenytoin, Probenecid, Rifampicin, Valproic Acid	No Yes
Dose per Administration	(xxxxxxxxxxxxx.yy)

Dose Unit	g
	g/cm2
	IU
	IU/mL
	kg
	L
	mg
	mg/L
	mg/m2/wk
	mL
	mmol
	ng
	Puff
	Tablet
	ug
	mL/dose
	uL
	mEq

Dose Form
Aerosol
Cream
Gel
Granule
Inhalant
Injection
Intrauterine Device
Ointment
Pill
Plaster
Salve
Solution
Spray
Suspension
Syrup
Tablet
Tampon

Dosing Frequency per Interval

1 Time per Week
2 Times per Week
3 Times per Week
4 Times per Week
BID (Twice Daily)
Continuous
Every Week
Once
PRN (As Needed)
Once per Day
QID (Four Times Daily)
Every Night
TID (Three Times Daily)
Twice
Unknown

Route of Administration	Cutaneous
	Intragingival
	Intramuscular
	Intraocular
	Intrauterine
	Intravenous
	Nasal
	Ophthalmic
	Oral
	Rectal
	Respiratory (Inhalation)
	Subcutaneous
	Topical
	Transdermal
	Unassigned
	Vaginal
Indication for Therapy (select all that apply)	
If the drug is used for contraception, select Prophylaxis as the indication.	
Adverse Event	
Please provide a link to corresponding Adverse Event record(s).	
Baseline Condition	
Please provide a link to corresponding Baseline Condition record(s).	
Medical History	
Please provide a link to corresponding Medical History record(s).	
Concomitant Procedure	

Please provide a link to corresponding Concomitant Procedure record(s).

Disease Under Study

Prophylaxis

Concomitant Procedures / Non-Drug Therapies (PR_01_v001)

Concomitant Procedures / Non-Drug Therapies	
Procedure/Non-Drug Therapy <i>(Enter the procedure or non-drug therapy name. Surgery is a procedure, and not an adverse event. Pre-planned surgeries should also be reported as a procedure/non-drug therapy.)</i>	
Was procedure/non-drug therapy started prior to date of informed consent?	No
	Yes
Start Date	
Procedure/Non-Drug Therapy Ongoing	No
	Yes
End Date	
Indication for Concomitant Procedures / Non-Drug Therapies (Select all that apply)	
If the non-drug therapy is used for contraception, select Prophylaxis as the indication.	
Adverse Event	
Please provide a link to corresponding Adverse Event record(s).	
Baseline Condition	
Please provide a link to corresponding Baseline Condition record(s).	
Medical History	
Please provide a link to corresponding Medical History record(s).	
Disease Under Study	
Prophylaxis	

Demographics (DM_01_v002)

Demographics	
Birth Year (transferred by IRT) (Value has been transferred from the IRT vendor. If corrections are needed, please contact the IRT vendor.)	Value calculated by the system
Age (at time of Informed Consent; transferred by IRT) (Value has been transferred from the IRT vendor. If corrections are needed, please contact the IRT vendor.)	Value calculated by the system
Sex (transferred by IRT) (Value has been transferred from the IRT vendor. If corrections are needed, please contact the IRT vendor.)	Value calculated by the system
If female, is the subject of childbearing potential?	☐ No ☐ Yes
Gender Identity (Subject self-identified gender regardless of geno-/pheno-typic natal sex and independent whether steps have been taken to affirm gender via medication or surgery.)	☐ Male ☐ Female ☐ Non-Binary ☐ Other ☐ Not Answered
If Other, Specify	
Ethnicity (Hispanic or Latino is a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race. It includes also 'Spanish origin'.)	☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race (self-reported; select all applicable, but at least one)	
☐ American Indian or Alaska Native	
☐ Asian	
☐ Black or African American	
☐ Native Hawaiian or Other Pacific Islander	

White

Asian subcategorization (self-reported; select all applicable, but at least one)
Asian Indian
Chinese
Japanese
Korean
Southeast Asian
Taiwanese
Other Asian

Native Hawaiian or Other Pacific Islanders subcategorization (self-reported; select all applicable, but at least one)
Aboriginal or Torres Strait Islander
Native Hawaiian
Other Pacific Islander

Drug Administration - Empagliflozin (EC_01_v002_EMPA)

Drug Administration - Empagliflozin		
Drug Administered	No	
	Yes	
Administration Date		
Administration Time	:	24 hour clock
Reason Dose Not Administered	Subject Refused	
	Administrative Reason	

Drug Administration - Vicadrostat/Placebo (EC_01_v002_VICA)

Drug Administration - Vicadrostat/Placebo	
Drug Administered	No Yes
Administration Date	
Administration Time	: 24 hour clock
Reason Dose Not Administered	Subject Refused Administrative Reason

Drug Administration Interruption - Empagliflozin (EC_INT_EMPA)

Drug Administration Interruption of Empagliflozin	
Since the last visit, was drug interrupted due to adverse event for any duration, or for any other reason for more than 7 days?	No
	Yes
If Yes, was interruption due to AE	No
	Yes
Please select associated Adverse Event	
Date stopped	
Date restarted	

Drug Administration Interruption - Vicadrostat/Placebo (EC_INT_VICA)

Drug Administration Interruption of Vicadrostat/Placebo	
Since the last visit, was drug interrupted due to adverse event for any duration, or for any other reason for more than 7 days?	No
	Yes
If Yes, was interruption due to AE	No
	Yes
Please select associated Adverse Event	
Date stopped	
Date restarted	

Drug Dispense (DA_ACTUAL_01_v001)

Drug Dispense
Dispensed Date
Dispensed Medication Number <i>(Provide information for dispensed kits including replacement and unscheduled kits, as well as those not assigned by IRT and dispensed in error. Do not enter medications which were assigned by IRT but not dispensed.)</i>

Eligibility (ELIG_01_v001)

Eligibility
Form must be submitted by the site in all cases; data derived from IRT. If subject is not randomized due to 'Other' reason, 'Other, Specify' must be data entered manually.
Was the subject randomized? (transferred by IRT) <i>(Value has been transferred from the IRT vendor. If corrections are needed, please contact the IRT vendor. If subject is randomized despite violation of In-/Exclusion (IE) criteria, mark the answer as yes and enter the violated criteria on the In-/Exclusion (IE) form.)</i> Value calculated by the system
If No, Primary Reason (transferred by IRT) <i>(Value has been transferred from the IRT vendor. If corrections are needed, please contact the IRT vendor. If Screen Failure is selected, there should be at least one violated In-/Exclusion Criterion reported.)</i> Value calculated by the system
If Other, Specify
Randomization Date (transferred by IRT) <i>(Value has been transferred from the IRT vendor. If corrections are needed, please contact the IRT vendor.)</i> Value calculated by the system
Randomization Time (transferred by IRT) <i>(Value has been transferred from the IRT vendor. If corrections are needed, please contact the IRT vendor.)</i> Value calculated by the system

End of Study (EOS_01_v002)

End of Study	
Did the subject complete the planned observation period? <i>(Completion of the observation period as indicated in the protocol, which is independent of the completion or discontinuation of the treatment (i.e., subject can discontinue treatment prematurely, but can still complete the planned observation period).)</i>	No Yes
If Yes, End of Study Participation Date <i>(End of participation date is the last date of any assessment for the subject within the study (e.g.: subject completed the study).)</i>	
If No, Primary Reason	Withdrawal by Subject Death Lost To Follow-Up Other
'Withdrawal by Subject' was selected as Primary Reason for non-completion. Please add a respective entry on the 'Withdrawal of Informed Consents' form in the Common Forms event.	
Did the subject explicitly decide to have her/his not yet analyzed samples destroyed?	No Yes
If Other, Specify <i>(Describe any reason not covered by the above categories (e.g., investigator decision to withdraw subject))</i>	
If Other, Other Date <i>(Enter the date of other reason for non-completion.)</i>	
If Death, Death Date <i>(Enter the date of death in case the subject died.)</i>	
If Lost to Follow-Up, what was the date the subject was last successfully contacted by the site or known to be alive? <i>(Enter the date the subject was last successfully contacted by the site or known to be alive, in case the subject was lost to follow-up.)</i>	
Is it planned that the subject will continue into the [study number] [rollover/extension] study? <i>(Enter whether the subject will continue into the rollover/extension study.)</i>	No Yes

Events since last Visit (ESLV)

Events since last Visit	
Is patient receiving the best possible or tolerated treatment for HF and other common concomitant diseases or symptoms?	No Yes
If No, indicate reason why	Cost/access reasons Patient preference/non-compliance, but not intolerance
Was the intensity of diuretic therapy changed since last visit?	Intensified No change Decreased Not Applicable
Was the intensity of antihypertensive therapy changed since last visit?	Intensified No change Decreased Not Applicable

HCRU: Hospitalization, ER Visit, Unplanned Outpatient Visit (ER_HOSP_001)

Hospitalization	
Was hospitalization planned at randomization?	No Yes
If not planned, select associated Adverse Event which is the primary cause	
Was an ambulance required?	No Yes
Type of visit (select all that apply):	
Hospitalization	
Emergency room	
Unplanned Outpatient Visit (urgent or unscheduled visit to office or practice)	
Urgent Care Center	
If Emergency room: Date of ER visit	
If Unplanned outpatient visit (urgent or unscheduled visit to office or practice): Date of office/practice visit	
Duration of Stay in ER	< 12 Hours ≥ 12 Hours and < 24 Hours ≥ 24 Hours
Date of Urgent Care Center Visit	
If Hospitalization: Hospital admission Date	
Hospital Discharge Date	
Duration of Stay at Hospital	< 12 Hours ≥ 12 Hours and < 24 Hours ≥ 24 Hours

Stays in Intensive care unit (ICU) or Coronary Care Unit (CCU)?	No
	Yes
If Yes, Number of days	
If less than 1 day please record number of hours per stay	
Was visit / hospitalization related to heart failure?	No
<i>(If Yes, please complete the Details on Heart Failure Symptoms and Findings below.)</i>	Yes

Details of Heart Failure Symptoms and Findings	
Please document new or worsening symptoms due to HF	
Was visit related to the primary diagnosis or worsening of heart failure in the opinion of the treating physician?	No
	Yes
Dyspnoea	No
	Yes
Decreased exercise tolerance	No
	Yes
Fatigue	No
	Yes
Other symptoms of worsened end--organ perfusion or volume overload	No
	Yes
If Other symptoms please specify	
Please document the objective evidence of physical examination findings	

Peripheral edema	No
	Yes
Increasing abdominal distention or ascites	No
	Yes
Pulmonary rales/crackles/crepitations	No
	Yes
Increased jugular venous pressure and/or hepatojugular reflux	No
	Yes
S3 gallop	No
	Yes
Clinically significant or rapid weight gain thought to be related to fluid retention	No
	Yes
Other	No
	Yes
If Other please specify	
Please document objective evidence of laboratory findings	
Increased BNP/NT proBNP concentrations consistent with decompensation of heart failure	No
	Yes
If available, please provide BNP value:	
Date of BNP sampling	

If available, please provide NT-proBNP value:	
Date of NT-proBNP sampling	
Radiological or ultrasonographic evidence of pulmonary congestion	No Yes
Noninvasive diagnostic evidence of clinically significant elevated left or right sided ventricular filling pressure or low cardiac output	No Yes
Invasive evidence of new or worsening HF including right heart catheterization showing elevated pulmonary capillary wedge pressure (pulmonary artery occlusion pressure), elevated central venous pressure, depressed cardiac index, or left heart catheterization showing elevated left ventricular end-diastolic pressure consistent with decompensation of HF	No Yes
Other laboratory criteria (e.g., elevated transaminases consistent with decompensated HF)	No Yes
If Other please specify laboratory criteria	
Initiation or Intensification of treatment: (Please enter also medications/therapies on concomitant medication/therapy eCRF forms.)	
Significant augmentation in oral diuretic therapy (for example, the doubling of diuretic dose; initiation of maintenance diuretic therapy; or initiation of combination diuretic therapy to relieve congestion)	No Yes
Has this significant augmentation of oral diuretic therapy been sustained for a period of at least 7 days?	No Yes
Initiation of intravenous diuretic (a single dose is sufficient)	No Yes

Initiation of an intravenous vasoactive agent (catecholamine, phosphodiesterase-3 inhibitor, other vasopressor, vasodilator)	No
	Yes
Mechanical or surgical intervention	No
	Yes
If mechanical or surgical intervention please specify	Mechanical Circulatory Support
	Mechanical Fluid Removal
Was any of the following therapies prescribed as treatment for Heart Failure: new renin-angiotensin system inhibitor, angiotensin receptor neprilysin inhibitors, beta-blocker, MRA, ivabradine, digoxin, vericiguat, hydralazine/isosorbide dinitrate or switching thiazide to loop diuretic?	No
	Yes
Does the subject have signs of structural heart disease (e.g. LA enlargement, diastolic dysfunction, elevated Pulmonary artery pressure, LV-Hypertrophy)?	No
	Yes
If yes, select all that apply:	
LA enlargement	
Diastolic dysfunction	
Elevated pulmonary artery pressure	
LV hypertrophy	
Associated Concomitant Medication for HF treatment at Hospital Admission	
Hospital Admission	
Associated Concomitant Medication	
Associated Concomitant Medication for HF treatment at Hospital Discharge	
Hospital Discharge	
Associated Concomitant Medication	
Associated Concomitant Procedures (non-drug therapies) for HF Treatment	
Concomitant Procedure Link	

Inclusion/Exclusion (IE_01_v001)

Inclusion/Exclusion	
Global Protocol Version Number	
Local Protocol Version Number	
If local version is not applicable mark Intentionally Left Blank.	
Did the subject meet all eligibility criteria?	No
	Yes
If No, list the criteria not met by the subject (add new line for each criterion violated)	

Criteria Not Met	
Criterion Category	Exclusion Criteria
	Inclusion Criteria
Criterion Number from Protocol (Criterion number from protocol (e.g. '1', '13', '2A').)	

Informed Consent (IC_01_v001)

Informed Consent	
Informed Consent Type <i>(Every informed consent requested by the protocol needs to be reported.)</i>	Main Other - Tokenization Other - VCT Other - Scout Other - Omnitrace
Informed Consent Version ID <i>(Enter Version ID (e.g., M_V01_DEU01_1-01) as printed on the paper IC on the lower left corner. Re-consents should be entered as a new row.)</i>	
Informed Consent Obtained	No Yes
Informed Consent Date	

IRT Landing Form (IRT_01_v002)

IRT Drug Allocation	
Medication Assignment Date	
Assigned Medication Number	
Medication Number Type Code	MEDASS
	MEDDIS
	MEDREP

IRT Data Derived to eCRF Items	
Birth Year	
Sex	Male
	Female
Age	
Was the subject randomized/entered?	No
	Yes
If No, Primary Reason	Adverse Event
	Screen Failure
	Screened in Error
	Lost to Follow-Up
	Withdrawal by Subject
	Other
Randomization/Entered Date	
Randomization/Entered Time	: 24 hour clock
Randomization Number	
Previous Subject Number	
Subject Stratification 1	

Subject Stratification Result 1

Pregnancy Test (Serum) (PREG_02_v001)

Pregnancy Test (Serum)	
Pregnancy Test Result	Negative
	Positive
	Not Done

Pregnancy Test (Urine) (PREG_01_v001)

Pregnancy Test (Urine)	
Pregnancy Test Result	Negative
	Positive
	Not Done

Sampling for Pre-Specified Testing and Sample Banking (BESAMPLE_01_v001)

Sampling for Pre-Specified Testing and Sample Banking

Sample Type	Archived Tumor Tissue Testing
	Biobanking
	Blood Banking
	CSF Banking
	DNA Banking
	DNA Testing
	Fresh Tumor Tissue Testing
	HLA-Typing
	RNA Banking
	RNA Testing
	Skin Biopsy
	T-cell Receptor Sequencing and Gene Expression
	Tissue Banking
	Tumor Tissue Testing
	Serum Banking
	DNA Re-sequencing
	RNA Sequencing
	Gene Expression
	Histopathology
	Immunohistochemistry
	Methylation Pattern
	cfDNA Testing
	Genomic DNA Testing
	Microbiome
	Skin Tape Stripping

Protein Binding

Plasma Banking

Sputum Banking

DNA Sequencing

Stool Sampling

Stool Banking

Urine Banking

Microbiome - miRNA

miRNA Profiling

Specimen Type	Archival Tumor Sample
	Fresh Tumor Sample
	Archival Tumor Tissue
	Blood
	CSF
	Fresh Tumor Tissue
	Lesional Skin
	Lesional Tissue
	Non-Lesional Skin
	Non-Lesional Tissue
	Plasma
	Serum
	Sputum
	Tissue
	Urine
	Urine Sediment
	Urine Supernatant
	Mucosa
	Control Sample
	Skin
	Stool
Sample Taken	No
	Yes
Sample Date	

Serum Cortisol (SER_CORT_01)

Cortisol			
Was Cortisol collected?		No	
		Yes	
Time of awaking		:	24 hour clock
Date of Sample Collection			
Time of Sample Collection		:	24 hour clock
Result		mcg/dL	
		nmol/L	
Specimen Type		Serum	
		Plasma	

Standard of Care - Screening (SOC_01_SCR)

Standard of Care - Screening	
Is the patient treated to the best standard of care for the management of all cardiovascular, renal and weight-related complications?	No
	Yes

Standard of Care - Treatment (SOC_01_TRT)

Standard of Care - Treatment	
Is the patient treated to the best standard of care for the management of all cardiovascular, renal and weight-related complications?	No Yes
In case of an occurrence of a cardiovascular event since the last visit, it must be reported on the Adverse Event form.	

Study Medication Compliance (COMP_01_v001)

Study Medication Compliance	
Study Medication Taken According to Protocol	No
	Yes
If No, Specify	
Did any Abuse / Misuse occur? (Any intentional, excessive, or inappropriate usage of study drug not according to the label instructions.)	No
	Yes
If Yes, Abuse / Misuse Details	
Was an Adverse Event associated with the Abuse / Misuse?	No
	Yes

Subject Retention (SUBJRETEN)

Subject Retention	
If study medication was prematurely discontinued, did the subject agree to continue to conduct regularly scheduled study visits per protocol early discontinuation option 1?	No
	Yes
If no, did the subject agree to complete the regularly scheduled visits remotely per protocol early discontinuation option 2?	No
	Yes
If no, did the subject agree to come to the site or be contacted periodically per protocol early discontinuation option 3?	No
	Yes
If no, did the subject agree on a final contact at the planned end of trial per protocol early discontinuation option 4?	No
	Yes
If no, did the subject allow information to be obtained through medical records and to collect vital status at the end of trial per protocol early discontinuation option 5?	No
	Yes
Is the patient potentially lost to follow-up?	No
	Yes

Substance Use (SU_01_v001)

Sustance Use	
Has the subject ever used tobacco? <i>(Does not include the use of e-cigarettes. Currently, e-cigarette use is not to be taken into account to define the subject's smoking history. The recommendation, based on current knowledge, is that e-cigarette users should not be considered active smokers, if not otherwise defined in the protocol. If a subject has switched from traditional cigarettes to e-cigarettes, Former should be marked.)</i>	Never
	Current
	Former
Has the subject ever used nicotine? <i>(Includes patches, gums, cigarettes, e-cigarettes.)</i>	Never
	Current
	Former
Has the subject ever used vaping products/devices or e-cigarettes?	Never
	Current
	Former
Has the subject ever consumed alcohol?	Never
	Current
	Former

Treatment Period Summary (TPS_01_v001)

Treatment Period Summary	
Did the subject complete the planned treatment period? (Completion of the treatment period as indicated by the protocol.)	Completed Prematurely Discontinued Never Started
Date of Last Administration of Study Medication (Enter the date of last intake of the study medication, when known (even if only partial information is known i.e. month/year or year). Every effort should be made to obtain this information from the subject or a relative. For Lost to Follow-Up subjects with remaining study medication, the date should be left blank.)	
Treatment Discontinuation Decision (Withdrawal of study treatment by subject or investigator does not imply the withdrawal of participation from the overall study, i.e., the observation period is still expected to be completed per protocol.)	Physician Decision Subject Decision Lost to Follow-Up Study Terminated by Sponsor Site Terminated by Sponsor Death Other
If Other, Specify	

Primary Treatment Discontinuation Reason	Adverse Event
	Lack of Efficacy
	Change of Residence
	Burden of Study Procedures
	Technical Problems
	Protocol Deviation
	Other
	No Reason Available
If Technical Problems, Protocol Deviation, or Other, Specify	
Reason Subject Not Treated (Withdrawal by Subject = Subject refuses treatment, but may stay in study for subsequent visits.)	Subject Decision
	Randomized by Mistake
	Adverse Event
	Other
Other Reason Subject Not Treated, Specify	

Medication Code Broken	
Was the study medication unblinded by the site?	No
	Yes
Date Medication Code Broken	

Reason Medication Code Broken	Adverse Event
	Other
If Other, Specify	
If Adverse Event, report the primary AE leading to medication code being broken.	
Primary Adverse Event	

Unscheduled Visit Selection (UNSCHED_01_v002)

Unscheduled Visit Selection
Select all forms to be added to the unscheduled visit
Form Name
Form Name_1
Form Name_2
Form Name_3
Form Name_4
Form Name_5
Form Name_6
Form Name_7
Form Name_8
Form Name_9
Form Name_10
Form Name_11
Form Name_12

Vital Signs (VS_01_v001)

Vital Signs		
Planned Time Point Name	Measurement 1	
	Measurement 2	
	Measurement 3	
Measurement Date		
Measurement Time	:	24 hour clock
Systolic Blood Pressure	mmHg	
Diastolic Blood Pressure	mmHg	
Pulse Rate	beats/min	
Height	cm	
(Enter a value without a decimal (e.g.: 180). If necessary, round off the value to the closest whole number (e.g. for 179.6, enter 180).)		
Weight	(xxxx.y)	kg
(Enter a value with 1 digit after the decimal place (e.g.: 58.5). If necessary, round the value off to one decimal place (e.g. for 58.54, enter 58.5).)		

Vital Status (VITSTAT_01_v003)

Vital Status	
Vital Status Date <i>(Date when Vital Status was confirmed. If subject is Dead, this may be the date of death or after the actual date of death. If status is Unknown, enter the date the subject was last known to be alive.)</i>	
Subject Status	Alive Dead Unknown
If subject died, follow reporting instructions as outlined in the protocol.	
Information Source <i>(Source from which the information about the subject was received.)</i>	Study Subject Family Member Friend Caregiver Health Care Professional Public Database

Withdrawal of Informed Consents (WIC_01_v002)

Withdrawal of Informed Consents
Informed Consent Record
Withdrawal Date