

Study Reference:

Study Type:

Study Aim:

Date:

Evaluator:

General: Note sponsorship, funding and affiliations, recognizing that any entity or person involved in research may have a bias.

Study Design Assessment	<input type="checkbox"/> Is the design appropriate to the research question? Is the research question useful? <input type="checkbox"/> For efficacy , use of experimental study design (meaning there was no choice made to determine intervention) <input type="checkbox"/> Clinically significant area for study (morbidity, mortality, symptom relief, functioning and health-related quality of life) and reasonable definitions for clinical outcome such as response, treatment success or failure <input type="checkbox"/> If composite endpoints used, reasonable combination used — and used for safety if used for efficacy
Internal Validity Assessment	<input type="checkbox"/> Can bias, confounding or chance explain the study results? <input type="checkbox"/> Ensure prespecified and appropriate 1) research questions, 2) populations to analyze, and 3) outcomes
Selection Bias	<input type="checkbox"/> Groups are appropriate for study, of appropriate size, concurrent and similar in prognostic variables <input type="checkbox"/> Methods for generating the group assignment sequence are truly random , sequencing avoids potential for anyone affecting assignment to a study arm and randomization remains intact <input type="checkbox"/> Concealment of allocation strategies are employed to prevent anyone affecting assignment to a study arm
Performance Bias	<input type="checkbox"/> Double-blinding methods employed (i.e., subject and all working with the subject or subject's data) and achieved <input type="checkbox"/> Reasonable intervention and reasonable comparator used (e.g., placebo) <input type="checkbox"/> No bias or difference, except for what is under study, between groups during course of study (e.g., intervention design and execution, care experiences, co-interventions, concomitant medication use, adherence, inappropriate exposure or migration, cross-over threats, protocol deviations, measurement methods, study duration, changes due to time etc.)
Attrition Bias	<input type="checkbox"/> Might attrition, including missing data, discontinuations or loss to follow-up, have resulted in distorted outcomes?
Assessment Bias	<input type="checkbox"/> Assessors are blinded <input type="checkbox"/> Low likelihood of findings due to chance, false positive and false negative outcomes <input type="checkbox"/> Non-significant findings are reported, but the confidence intervals include clinically meaningful differences <input type="checkbox"/> Intention-to-Treat Analysis (ITT) performed for efficacy (not safety) (all people are analyzed as randomized + reasonable method for imputing missing values which puts the intervention through a challenging trial or reasonable sensitivity analysis) or missing values are very small. <input type="checkbox"/> If time-to-event analysis performed, appropriate, transparent and unbiased. <input type="checkbox"/> Analysis methods are appropriate and use of modeling only with use of reasonable assumptions <input type="checkbox"/> No problems of selective reporting
Usefulness	<input type="checkbox"/> Clinically significant area + sufficient benefit size = meaningful clinical benefit (consider efficacy vs effectiveness)
External Validity	<p>How likely are research results to be realized in the real world considering population and circumstances for care?</p> <input type="checkbox"/> Review n, inclusions, exclusions, baseline characteristics and intervention methods — this is a judgment call .
Patient Perspective	<input type="checkbox"/> Consider benefits, harms, risks, costs, uncertainties, alternatives and satisfaction
Provider Perspective	<input type="checkbox"/> Satisfaction, acceptability (includes adherence issues, potential for abuse, dependency issues), likely appropriate application and actionability (e.g., FDA approval, affordability, external relevance, circumstances of care, able to apply, tools available)

- Non-Inferiority & Equivalence Supplement:** Absence of the following problems: lack of sufficient evidence confirming efficacy of referent treatment; study not sufficiently similar to referent study; inappropriate Deltas; or significant biases or analysis methods which would tend to diminish an effect size (e.g., conservative application of ITT analysis, insufficient power, etc.)
- Diagnostic Test Supplement:** New test requires better outcomes or value. Test is compared to gold standard or reasonable comparator and finds same abnormality and within time period that does not result in a change in diagnosis. Test is applied to all or random sample of subjects with and without disease. Assessors are blinded. There is minimal bias from indeterminate results. Measures of test function are useful.
- Screening Supplement:** Early diagnosis and treatments determined to be effective will improve outcomes more than later diagnosis and treatment. Beneficial outcomes are not explained by bias (e.g., lead time, length, overdiagnosis or volunteer bias).