Form 2400 R5.0: Pre-Transplant Essential Data

Center: CRID:

Key Fields

OMB No: 0915-0310

Expiration Date: 1/31/2020

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0310. Public reporting burden for this collection of information is estimated to average 1.0 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-29, Rockville, Maryland, 20857.

Sequence Number: _____

Date Received: __ __ __ __ - __ __- __ __

Center Identification

CIBMTR Center Number: _____

EBMT Code (CIC): _____

Hospital: _____

Unit (check only one)

○ Adult ○ Pediatric

Recipient Identification

CIBMTR Research ID: (CRID) _____

Recipient Data

Questions: 1 - 10

1 Date of birth: __ __ __ __ - __ __- __ __

2 Sex

○ male ○ female

3 Ethnicity

○ Hispanic or Latino

○ Not Hispanic or Latino

○ Not applicable (not a resident of the USA)

○ Unknown

Race (1)

Questions: 4 - 4

4 Race _____

5 Zip or postal code for place of recipient's residence: (USA recipients only) _____

6 Is the recipient participating in a clinical trial?

○ yes ○ no

Clinical Trials (1)

Questions: 7 - 10

7 Study Sponsor _____

8 Specify other sponsor: _____

9 Study ID Number _____

10 Subject ID: _____

Hematopoietic Cellular Transplant (HCT)

Questions: 11 - 28

11 Date of this HCT: __ __ __ __ - __ __- __ __

12 Was this the first HCT for this recipient?

○ yes ○ no

13 Is a subsequent HCT planned as part of the overall treatment protocol (not as a reaction to post-HCT disease assessment)? **(For autologous HCTs only)**

○ yes ○ no

14 Specify subsequent HCT planned

○ Autologous ○ Allogeneic

15 Specify the number of prior HCTs: _____

Specify the HSC source(s) for all prior HCTs:

16 Autologous

○ yes ○ no

17 Allogeneic, unrelated

○ yes ○ no

18 Allogeneic, related

○ yes ○ no

19 Syngeneic
- yes
- no

20 Date of the last HCT: (just before current HCT) __ __ __ __ - __ __- __ __

21 Was the last HCT performed at a different institution?
- yes
- no

Specify the institution that performed the last HCT:

22 Name: _____

City: _____

State: _____

Country: _____

23 What was the HSC source for the last HCT?
- Autologous
- Allogeneic, unrelated donor
- Allogeneic, related donor

24 Reason for current HCT _____

25 Date of graft failure / rejection: __ __ __ __ - __ __- __ __

26 Date of relapse: __ __ __ __ - __ __- __ __

27 Date of secondary malignancy: __ __ __ __ - __ __- __ __

28 Specify other reason: _____

Donor Information

Questions: 29 - 63

29 Multiple donors?
- yes
- no

30 Specify number of donors: _____

Donor Information for this HCT (1)

Questions: 31 - 63

31 Specify donor _____

32 NMDP cord blood unit ID: _____

33 NMDP donor ID: _____

34 Non-NMDP unrelated donor ID: (not applicable for related donors) _____

35 Non-NMDP cord blood unit ID: (include related and autologous CBUs) _____

36 Is the CBU ID also the ISBT DIN number?
- yes
- no

37 Specify the ISBT DIN number: _____

38 Registry or UCB Bank ID _____

39 Specify other Registry or UCB Bank: _____

40 Specify the related donor type
- Syngeneic (monozygotic twin)
- HLA-identical sibling (may include non-monozygotic twin)
- HLA-matched other relative
- HLA-mismatched relative

41 Date of birth (donor / infant)
- Known
- Unknown

42 Date of birth: (donor / infant) __ __ __ __ - __ __- __ __

43 Age (donor / infant)
- Known
- Unknown

44 Age: (donor / infant) _____
- Months (use only if less than 1 year old)
- years

45 Sex (donor / infant)
- male
- female

Specify product type:

46 Bone marrow
- yes
- no

47 PBSC
- yes
- no

48 Single cord blood unit
- yes
- no

49 Other product
- yes
- no

50 Specify other product type: _____

Center: CRID:

A series of collections should be considered a single product when they are all from the same donor and use the same collection method and technique (and mobilization, if applicable), even if the collections are performed on different days.

51 Specify number of products infused from this donor: _____

52 Specify the number of these products intended to achieve hematopoietic engraftment: _____

Questions 53 – 60 are for autologous HCT recipients only. If other than autologous skip to question 61

53 Did the recipient have more than one mobilization event to acquire cells for HCT?

○ yes ○ no

54 Specify the total number of mobilization events performed for this HCT: (regardless of the number of collections or which collections were used for this HCT) _____

Specify all agents used in the mobilization events reported above:

55 G-CSF

○ yes ○ no

56 GM-CSF

○ yes ○ no

57 Pegylated G-CSF

○ yes ○ no

58 Plerixafor (Mozobil)

○ yes ○ no

59 Other CXCR4 inhibitor

○ yes ○ no

60 Combined with chemotherapy

○ yes ○ no

61 Was this donor used for any prior HCTs?

○ yes ○ no

62 Donor CMV-antibodies (IgG or Total) **(Allogeneic HCTs only)**

○ Reactive
○ Non-reactive
○ Not done
○ Not applicable (cord blood unit)

63 Was plerixafor (Mozobil) given at any time prior to the preparative regimen? **(Related HCTs only)**

○ yes ○ no ○ Unknown

Consent

Questions: 64 - 71

64 Has the recipient signed an IRB-approved consent form for submitting research data to the NMDP / CIBMTR?

○ Yes (patient consented)
○ No (patient declined)
○ Not approached

65 Date form was signed: __ __ __ __ - __ __- __ __

66 Did the recipient give permission to be directly contacted for future research?

○ Yes (patient provided permission)
○ No (patient declined)
○ Not approached

67 Date form was signed: __ __ __ __ - __ __- __ __

68 Has the recipient signed an IRB-approved consent form to donate research blood samples to the NMDP / CIBMTR?

○ Yes (patient consented)
○ No (patient declined)
○ Not approached
○ Not applicable (center not participating)

69 Date form was signed: __ __ __ __ - __ __- __ __

70 Has the donor signed an IRB-approved consent form to donate research blood samples to the NMDP / CIBMTR? **(Allogeneic donors only)**

○ Yes (donor consented)
○ No (donor declined)
○ Not approached
○ Not applicable (center not participating)

71 Date form was signed: __ __ __ __ - __ __- __ __

Product Processing / Manipulation

Questions: 72 - 90

72 Was the product manipulated prior to infusion?
yes no

73 Specify portion manipulated
entire product portion of product

Specify all methods used to manipulate the product:

74 Washed
yes no

75 Diluted
yes no

76 Buffy coat enriched (buffy coat preparation)
yes no

77 B-cell reduced
yes no

78 CD8 reduced
yes no

79 Plasma reduced (removal)
yes no

80 RBC reduced
yes no

81 Cultured (ex-vivo expansion)
yes no

82 Genetic manipulation (gene transfer / transduction)
yes no

83 PUVA treated
yes no

84 CD34 enriched (CD34+ selection)
yes no

85 CD133 enriched
yes no

86 Monocyte enriched
yes no

87 Mononuclear cells enriched
yes no

88 T-cell depletion
yes no

89 Other cell manipulation
yes no

90 Specify other cell manipulation: _____

Clinical Status of Recipient Prior to the Preparative Regimen (Conditioning)

Questions: 91 - 94

91 What scale was used to determine the recipient's functional status?
Karnofsky (recipient age ≥ 16 years)
Lansky (recipient age < 16 years)

Performance score prior to the preparative regimen:

92 Karnofsky Scale (recipient age ≥ 16 years) _____

93 Lansky Scale (recipient age < 16 years) _____

94 Recipient CMV-antibodies (IgG or Total)
Reactive Non-reactive Not done

Comorbid Conditions

Questions: 95 - 155

95 Is there a history of mechanical ventilation?
yes no

96 Is there a history of proven invasive fungal infection?
yes no

97 Were there clinically significant co-existing diseases or organ impairment at time of patient assessment prior to preparative regimen? Source: Blood, 2005 Oct 15;106(8):2912-2919
yes no

98 Arrhythmia **- For example, any history of atrial fibrillation or flutter, sick sinus syndrome, or ventricular arrhythmias requiring treatment**
yes no Unknown

99 Cardiac **- Any history of coronary artery disease (one or more vessel-coronary artery stenosis requiring medical treatment, stent, or bypass graft), congestive heart failure, myocardial infarction, OR ejection fraction ≤ 50% on the most recent test**

yes no Unknown

100 Cerebrovascular disease **- Any history of transient ischemic attack, subarachnoid hemorrhage or cerebrovascular accident**

yes no Unknown

101 Diabetes **- Requiring treatment with insulin or oral hypoglycemics in the last 4 weeks but not diet alone**

yes no Unknown

102 Heart valve disease **- Except asymptomatic mitral valve prolapse**

yes no Unknown

103 Hepatic, mild **- Chronic hepatitis, bilirubin > upper limit of normal to 1.5 × upper limit of normal, or AST/ALT > upper limit of normal to 2.5 × upper limit of normal at the time of transplant OR any history of hepatitis B or hepatitis C infection**

yes no Unknown

104 Hepatic, moderate / severe **- Liver cirrhosis, bilirubin > 1.5 × upper limit of normal, or AST/ALT > 2.5 × upper limit of normal**

yes no Unknown

105 Infection **- For example, documented infection, fever of unknown origin, or pulmonary nodules requiring continuation of antimicrobial treatment after day 0**

yes no Unknown

106 Inflammatory bowel disease **- Any history of Crohn's disease or ulcerative colitis requiring treatment**

yes no Unknown

107 Obesity **- Patients with a body mass index > 35 kg/m^2 prior to the start of conditioning**

yes no Unknown

108 Peptic ulcer **- Any history of peptic ulcer confirmed by endoscopy and requiring treatment**

yes no Unknown

109 Psychiatric disturbance **- For example, depression, anxiety, bipolar disorder or schizophrenia requiring psychiatric consult or treatment in the last 4 weeks**

yes no Unknown

110 Pulmonary, moderate **- Corrected diffusion capacity of carbon monoxide and/or FEV$_1$ 66-80% or dyspnea on slight activity at transplant**

yes no Unknown

111 Pulmonary, severe **- Corrected diffusion capacity of carbon monoxide and/or FEV$_1$ ≤ 65% or dyspnea at rest or requiring oxygen at transplant**

yes no Unknown

112 Renal, moderate / severe **- Serum creatinine > 2 mg/dL or > 177 µmol/L or on dialysis at transplant, OR prior renal transplantation**

yes no Unknown

113 Rheumatologic **- For example, any history of systemic lupus erythmatosis, rheumatoid arthritis, polymyositis, mixed connective tissue disease, or polymyalgia rheumatica requiring treatment (do NOT include degenerative joint disease, osteoarthritis)**

yes no Unknown

114 Solid tumor, prior **- Treated at any time point in the patient's past history, excluding non-melanoma skin cancer, leukemia, lymphoma or multiple myeloma**

yes no Unknown

115 Breast cancer

yes no

116 Year of diagnosis: _____

117 Central nervous system (CNS) malignancy (glioblastoma, astrocytoma)

yes no

118 Year of diagnosis: _____

119 Gastrointestinal malignancy (colon, rectum, stomach, pancreas, intestine)

yes no

120 Year of diagnosis: _____

121 Genitourinary malignancy (kidney, bladder, ovary, testicle, genitalia, uterus, cervix)

yes no

122 Year of diagnosis: _____

123 Lung cancer

yes no

124 Year of diagnosis: _____

125 Melanoma

yes no

126 Year of diagnosis: _____

127 Oropharyngeal cancer (tongue, buccal mucosa)

yes no

128 Year of diagnosis: _____

129 Sarcoma

yes no

130 Year of diagnosis: _____

131 Thyroid cancer
yes no

132 Year of diagnosis: _____

133 Other co-morbid condition
yes no Unknown

134 Specify other co-morbid condition: _____

135 Was there a history of malignancy (hematologic or non-melanoma skin cancer) other than the primary disease for which this HCT is being performed?
yes no

Specify which malignancy(ies) occurred:

136 Acute myeloid leukemia (AML / ANLL)
yes no

137 Year of diagnosis: _____

138 Other leukemia, including ALL
yes no

139 Year of diagnosis: _____

140 Specify leukemia: _____

141 Clonal cytogenetic abnormality without leukemia or MDS
yes no

142 Year of diagnosis: _____

143 Hodgkin disease
yes no

144 Year of diagnosis: _____

145 Lymphoma or lymphoproliferative disease
yes no

146 Year of diagnosis: _____

147 Was the tumor EBV positive?
yes no

148 Other skin malignancy (basal cell, squamous)
yes no

149 Year of diagnosis: _____

150 Specify other skin malignancy: _____

151 Myelodysplasia (MDS) / myeloproliferative (MPN) disorder
yes no

152 Year of diagnosis: _____

153 Other prior malignancy
yes no

154 Year of diagnosis: _____

155 Specify other prior malignancy: _____

Pre-HCT Preparative Regimen (Conditioning)

Questions: 156 - 316

156 Height at initiation of pre-HCT preparative regimen: _____ inches centimeters

157 Actual weight at initiation of pre-HCT preparative regimen: _____ pounds kilograms

158 Was a pre-HCT preparative regimen prescribed?
yes no

159 Classify the recipient's prescribed preparative regimen **(Allogeneic HCTs only)**
Myeloablative
Non-myeloablative (NST)
Reduced intensity (RIC)

160 Date pre-HCT preparative regimen began: (irradiation or drugs) __ __ __ __ - __ __- __ __ **(Use earliest date from question 164 radiation, or 169 - 316 chemotherapy)**

161 Was irradiation planned as part of the pre-HCT preparative regimen?
yes no

162 What was the prescribed radiation field?
Total body
Total body by intensity-modulated radiation therapy (IMRT)
Total lymphoid or nodal regions
Thoracoabdominal region

163 Total prescribed dose: (dose per fraction x total number of fractions) _____ Gy cGy

164 Date started: __ __ __ __ - __ __- __ __

165 Was the radiation fractionated?
yes no

166 Prescribed dose per fraction: _____ ○ Gy ○ cGy

167 Number of days: *(include "rest" days)* _____

168 Total number of fractions: _____

Indicate the total prescribed cumulative dose for the preparative regimen:

169 ALG, ALS, ATG, ATS

○ yes ○ no

170 Total prescribed dose: _____ mg/kg

171 Date started: __ __ __ __ - __ __- __ __

172 Specify source

- ○ ATGAM (horse)
- ○ ATG - Fresenius (rabbit)
- ○ Thymoglobulin (rabbit)
- ○ Other

173 Specify other source: _____

174 Anthracycline

○ yes ○ no

175 Daunorubicin

○ yes ○ no

176 Total prescribed dose : _____ ○ mg/m2 ○ mg/kg

177 Date started: __ __ __ __ - __ __- __ __

178 Doxorubicin (Adriamycin)

○ yes ○ no

179 Total prescribed dose : _____ ○ mg/m2 ○ mg/kg

180 Date started: __ __ __ __ - __ __- __ __

181 Idarubicin

○ yes ○ no

182 Total prescribed dose : _____ ○ mg/m2 ○ mg/kg

183 Date started: __ __ __ __ - __ __- __ __

184 Rubidazone

○ yes ○ no

185 Total prescribed dose : _____ ○ mg/m2 ○ mg/kg

186 Date started: __ __ __ __ - __ __- __ __

187 Other anthracycline

○ yes ○ no

188 Total prescribed dose : _____ ○ mg/m2 ○ mg/kg

189 Date started: __ __ __ __ - __ __- __ __

190 Specify other anthracycline: _____

191 Bleomycin (BLM, Blenoxane)

○ yes ○ no

192 Total prescribed dose : _____ ○ mg/m2 ○ mg/kg

193 Date started: __ __ __ __ - __ __- __ __

194 Busulfan (Myleran)

○ yes ○ no

195 Total prescribed dose : _____

- ○ mg/m2
- ○ mg/kg
- ○ Target total AUC (µmol x min/L)

196 Date started: __ __ __ __ - __ __- __ __

197 Specify administration

○ Oral ○ IV ○ Both

198 Carboplatin

○ yes ○ no

199 Total prescribed dose : _____ ○ mg/m2 ○ mg/kg

200 Date started: __ __ __ __ - __ __- __ __

201 Were pharmacokinetics performed to determine preparative regimen drug dosing?

○ yes ○ no

202 Specify the target AUC: _____ mg/mL/minute

203 Cisplatin (Platinol, CDDP)

○ yes ○ no

204 Total prescribed dose : _____ ○ mg/m2 ○ mg/kg

205 Date started: __ __ __ __ - __ __- __ __

206 Cladribine (2-CdA, Leustatin)

yes no

207 Total prescribed dose : _____ mg/m2 mg/kg

208 Date started: __ __ __ __ - __ __- __ __

209 Corticosteroids (excluding anti-nausea medication)

yes no

210 Methylprednisolone (Solu-Medrol)

yes no

211 Total prescribed dose : _____ mg/m2 mg/kg

212 Date started: __ __ __ __ - __ __- __ __

213 Prednisone

yes no

214 Total prescribed dose : _____ mg/m2 mg/kg

215 Date started: __ __ __ __ - __ __- __ __

216 Dexamethasone

yes no

217 Total prescribed dose : _____ mg/m2 mg/kg

218 Date started: __ __ __ __ - __ __- __ __

219 Other corticosteroid

yes no

220 Total prescribed dose : _____ mg/m2 mg/kg

221 Date started: __ __ __ __ - __ __- __ __

222 Specify other corticosteroid: _____

223 Cyclophosphamide (Cytoxan)

yes no

224 Total prescribed dose : _____ mg/m2 mg/kg

225 Date started: __ __ __ __ - __ __- __ __

226 Cytarabine (Ara-C)

yes no

227 Total prescribed dose : _____ mg/m2 mg/kg

228 Date started: __ __ __ __ - __ __- __ __

229 Etoposide (VP-16, VePesid)

yes no

230 Total prescribed dose : _____ mg/m2 mg/kg

231 Date started: __ __ __ __ - __ __- __ __

232 Fludarabine

yes no

233 Total prescribed dose : _____ mg/m2 mg/kg

234 Date started: __ __ __ __ - __ __- __ __

235 Ifosfamide

yes no

236 Total prescribed dose : _____ mg/m2 mg/kg

237 Date started: __ __ __ __ - __ __- __ __

238 Intrathecal therapy (chemotherapy)

yes no

239 Intrathecal cytarabine (IT Ara-C)

yes no

240 Total prescribed dose : _____ mg/m2 mg/kg

241 Date started: __ __ __ __ - __ __- __ __

242 Intrathecal methotrexate (IT MTX)

yes no

243 Total prescribed dose : _____ mg/m2 mg/kg

244 Date started: __ __ __ __ - __ __- __ __

245 Intrathecal thiotepa

yes no

246 Total prescribed dose : _____ mg/m2 mg/kg

247 Date started: __ __ __ __ - __ __- __ __

248 Other intrathecal drug
yes no

249 Total prescribed dose : _____ mg/m2 mg/kg

250 Date started: __ __ __ __ - __ __- __ __

251 Specify other intrathecal drug: _____

252 Melphalan (L-Pam)
yes no

253 Total prescribed dose : _____ mg/m2 mg/kg

254 Date started: __ __ __ __ - __ __- __ __

255 Specify administration
Oral IV Both

256 Mitoxantrone (Novantrone)
yes no

257 Total prescribed dose : _____ mg/m2 mg/kg

258 Date started: __ __ __ __ - __ __- __ __

259 Monoclonal antibody
yes no

260 Radio labeled mAb
yes no

261 Total prescribed dose of radioactive component: _____ mCi MBq

262 Date started: __ __ __ __ - __ __- __ __

Specify radio labeled mAb:

263 Tositumomab (Bexxar)
yes no

264 Ibritumomab tiuxetan (Zevalin)
yes no

265 Other radio labeled mAb
yes no

266 Specify other radio labeled mAb: _____

267 Alemtuzumab (Campath)
yes no

268 Total prescribed dose : _____ mg/m2 mg/kg

269 Date started: __ __ __ __ - __ __- __ __

270 Rituximab (Rituxan, anti CD20)
yes no

271 Total prescribed dose : _____ mg/m2 mg/kg

272 Date started: __ __ __ __ - __ __- __ __

273 Gemtuzumab (Mylotarg, anti CD33)
yes no

274 Total prescribed dose : _____ mg/m2 mg/kg

275 Date started: __ __ __ __ - __ __- __ __

276 Other mAb
yes no

277 Total prescribed dose : _____ mg/m2 mg/kg

278 Date started: __ __ __ __ - __ __- __ __

279 Specify other mAb: _____

280 Nitrosourea
yes no

281 Carmustine (BCNU)
yes no

282 Total prescribed dose : _____ mg/m2 mg/kg

283 Date started: __ __ __ __ - __ __- __ __

284 CCNU (Lomustine)
yes no

285 Total prescribed dose : _____ mg/m2 mg/kg

286 Date started: __ __ __ __ - __ __- __ __

287 Other nitrosourea
yes no

288 Total prescribed dose : _____ ○ mg/m² ○ mg/kg

289 Date started: __ __ __ __ - __ __- __ __

290 Specify other nitrosourea: _____

291 Paclitaxel (Taxol, Xyotax)

○ yes ○ no

292 Total prescribed dose : _____ ○ mg/m² ○ mg/kg

293 Date started: __ __ __ __ - __ __- __ __

294 Teniposide (VM26)

○ yes ○ no

295 Total prescribed dose : _____ ○ mg/m² ○ mg/kg

296 Date started: __ __ __ __ - __ __- __ __

297 Thiotepa

○ yes ○ no

298 Total prescribed dose : _____ ○ mg/m² ○ mg/kg

299 Date started: __ __ __ __ - __ __- __ __

300 Treosulfan

○ yes ○ no

301 Total prescribed dose : _____ ○ mg/m² ○ mg/kg

302 Date started: __ __ __ __ - __ __- __ __

303 Tyrosine kinase inhibitors

○ yes ○ no

304 Dasatinib (Sprycel)

○ yes ○ no

305 Total prescribed dose : _____ ○ mg/m² ○ mg/kg

306 Date started: __ __ __ __ - __ __- __ __

307 Imatinib mesylate (STI571, Gleevec)

○ yes ○ no

308 Total prescribed dose : _____ ○ mg/m² ○ mg/kg

309 Date started: __ __ __ __ - __ __- __ __

310 Nilotinib

○ yes ○ no

311 Total prescribed dose : _____ ○ mg/m² ○ mg/kg

312 Date started: __ __ __ __ - __ __- __ __

313 Other drug

○ yes ○ no

314 Total prescribed dose : _____ ○ mg/m² ○ mg/kg

315 Date started: __ __ __ __ - __ __- __ __

316 Specify other drug: _____

GVHD Prophylaxis

Questions: 317 - 343

This section is to be completed for allogeneic HCTs only; autologous HCTs continue with question 344.

317 Was GVHD prophylaxis planned / given?

○ yes ○ no

Specify:

318 ALG, ALS, ATG, ATS

○ yes ○ no

319 Total dose: _____ mg/kg

320 Specify source

- ○ ATGAM (horse)
- ○ ATG - Fresenius (rabbit)
- ○ Thymoglobulin (rabbit)
- ○ Other

321 Specify other source: _____

322 Corticosteroids (systemic)

○ yes ○ no

323 Cyclosporine (CSA, Neoral, Sandimmune)

○ yes ○ no

324 Cyclophosphamide (Cytoxan)

○ yes ○ no

325 Extra-corporeal photopheresis (ECP)
yes no

326 FK 506 (Tacrolimus, Prograf)
yes no

327 In vivo monoclonal antibody
yes no

Specify in vivo monoclonal antibody:

328 Alemtuzumab (Campath)
yes no

329 Anti CD 25 (Zenapax, Daclizumab, AntiTAC)
yes no

330 Specify: _____

331 Etanercept (Enbrel)
yes no

332 Infliximab (Remicade)
yes no

333 Other in vivo monoclonal antibody
yes no

334 Specify antibody: _____

335 In vivo immunotoxin
yes no

336 Specify immunotoxin: _____

337 Methotrexate (MTX) (Amethopterin)
yes no

338 Mycophenolate mofetil (MMF) (CellCept)
yes no

339 Sirolimus (Rapamycin, Rapamune)
yes no

340 Blinded randomized trial
yes no

341 Specify trial agent: _____

342 Other agent
yes no

343 Specify other agent: _____

Other Toxicity Modifying Regimen

Questions: 344 - 344

Optional for non-U.S. Centers

344 Was KGF (palifermin, Kepivance) started or is there a plan to use it?
Yes No masked trial

Post-HCT Disease Therapy Planned as of Day 0

Questions: 345 - 357

345 Is this HCT part of a planned multiple (sequential) graft / HCT protocol?
yes no

346 Is additional post-HCT therapy planned?
yes no

Questions 347 – 357 are optional for non-U.S. centers

347 Bortezomib (Velcade)
yes no

348 Cellular therapy (e.g. DCI, DLI)
yes no

349 Dexamethasone
yes no

350 Intrathecal therapy (chemotherapy)
yes no

351 Tyrosine kinase inhibitor (e.g. imatinib mesylate)
yes no

352 Lenalidomide (Revlimid)
yes no

353 Local radiotherapy
yes no

354 Rituximab (Rituxan, MabThera)
yes no

355 Thalidomide (Thalomid)
yes no

356 Other therapy
yes no

357 Specify other therapy: _____

First Name: _____

Last Name: _____

E-mail address: _____

Date: __ __ __ __ - __ __ - __ __