

CIBMTR Center Number:

CIBMTR Recipient ID:

17. Were any liver biopsies performed for cytology and/or pathology prior to HSCT?

- 1 yes → **Attach a copy of liver cytology / pathology report(s).**
2 no

History of Antiviral Therapy for Hepatitis — Recipient

18. Did the recipient receive therapy for hepatitis prior to HSCT?

- 1 yes → **Continue with table below**
2 no → **Continue with question 74**

For the therapy table below, see “Reason Started” codes on page 3. Therapy paused for < 1 week should not be considered as “Therapy Stopped.”

Therapy Given?	Date Started			Daily Dose	Reason Started	Therapy Stopped?	Date Stopped							
Lamivudine	Month	Day	Year	mg	Code		Month	Day	Year					
19. First course														
1 <input type="checkbox"/> yes →	20.	<input type="text"/>	<input type="text"/>	21.	<input type="text"/>	22.	<input type="checkbox"/>	23.	1 <input type="checkbox"/> yes →	24.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 <input type="checkbox"/> no									2 <input type="checkbox"/> no					
25. Second course														
1 <input type="checkbox"/> yes →	26.	<input type="text"/>	<input type="text"/>	27.	<input type="text"/>	28.	<input type="checkbox"/>	29.	1 <input type="checkbox"/> yes →	30.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 <input type="checkbox"/> no									2 <input type="checkbox"/> no					
31. Third course														
1 <input type="checkbox"/> yes →	32.	<input type="text"/>	<input type="text"/>	33.	<input type="text"/>	34.	<input type="checkbox"/>	35.	1 <input type="checkbox"/> yes →	36.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 <input type="checkbox"/> no									2 <input type="checkbox"/> no					
Interferon														
37. First course														
1 <input type="checkbox"/> yes →	38.	<input type="text"/>	<input type="text"/>	39.	<input type="text"/>	40.	<input type="checkbox"/>	41.	1 <input type="checkbox"/> yes →	42.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 <input type="checkbox"/> no									2 <input type="checkbox"/> no					
43. Second course														
1 <input type="checkbox"/> yes →	44.	<input type="text"/>	<input type="text"/>	45.	<input type="text"/>	46.	<input type="checkbox"/>	47.	1 <input type="checkbox"/> yes →	48.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 <input type="checkbox"/> no									2 <input type="checkbox"/> no					
49. Third course														
1 <input type="checkbox"/> yes →	50.	<input type="text"/>	<input type="text"/>	51.	<input type="text"/>	52.	<input type="checkbox"/>	53.	1 <input type="checkbox"/> yes →	54.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 <input type="checkbox"/> no									2 <input type="checkbox"/> no					

Other antiviral therapy

55. Specify other antiviral therapy given: _____

56. First course														
1 <input type="checkbox"/> yes →	57.	<input type="text"/>	<input type="text"/>	58.	<input type="text"/>	59.	<input type="checkbox"/>	60.	1 <input type="checkbox"/> yes →	61.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 <input type="checkbox"/> no									2 <input type="checkbox"/> no					
62. Second course														
1 <input type="checkbox"/> yes →	63.	<input type="text"/>	<input type="text"/>	64.	<input type="text"/>	65.	<input type="checkbox"/>	66.	1 <input type="checkbox"/> yes →	67.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 <input type="checkbox"/> no									2 <input type="checkbox"/> no					
68. Third course														
1 <input type="checkbox"/> yes →	69.	<input type="text"/>	<input type="text"/>	70.	<input type="text"/>	71.	<input type="checkbox"/>	72.	1 <input type="checkbox"/> yes →	73.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 <input type="checkbox"/> no									2 <input type="checkbox"/> no					

Codes for Antiviral Therapy Started

- 1 Prophylaxis 2 Empiric therapy due to suspected infection 3 Documented infection 4 Planned post-HSCT therapy

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Serological Evidence of Prior Hepatitis Exposure / Infection — Donor

Specify and/or confirm previous hepatitis testing performed and reported on the Form 24 – Donor Infectious Disease Markers and History of Antigen Exposure and the Form 50 – Repeat Donor Infectious Disease Markers.

74. Hepatitis B core antibody (HBcAb) 1 positive 2 negative 3 inconclusive 4 not tested 5 confirm prior result
 75. Hepatitis B surface antigen (HBsAg) 1 positive 2 negative 3 inconclusive 4 not tested 5 confirm prior result
 76. Hepatitis B e antigen (HBeAg) 1 positive 2 negative 3 inconclusive 4 not tested
 77. Hepatitis C antibody (HCAb) 1 positive 2 negative 3 inconclusive 4 not tested 5 confirm prior result

Provide all documented hepatitis B viral load levels obtained within 3 months prior to the stem cell harvest. If no values were obtained in the 3 months prior to the donation, provide and date the most recent values obtained prior to the stem cell harvest.

- | | Month | Day | Year | | | Specify units: |
|-----------|----------------------|----------------------|-------------------------|-----------------------------------|----------------------|---|
| 78. Date: | <input type="text"/> | <input type="text"/> | 20 <input type="text"/> | 79. Hepatitis B viral load level: | <input type="text"/> | 1 <input type="checkbox"/> log IU
2 <input type="checkbox"/> IU/mL
3 <input type="checkbox"/> copies/mL
4 <input type="checkbox"/> pg/mL |
| 80. Date: | <input type="text"/> | <input type="text"/> | 20 <input type="text"/> | 81. Hepatitis B viral load level: | <input type="text"/> | 1 <input type="checkbox"/> log IU
2 <input type="checkbox"/> IU/mL
3 <input type="checkbox"/> copies/mL
4 <input type="checkbox"/> pg/mL |
| 82. Date: | <input type="text"/> | <input type="text"/> | 20 <input type="text"/> | 83. Hepatitis B viral load level: | <input type="text"/> | 1 <input type="checkbox"/> log IU
2 <input type="checkbox"/> IU/mL
3 <input type="checkbox"/> copies/mL
4 <input type="checkbox"/> pg/mL |

Provide all documented hepatitis C viral load levels obtained within 3 months prior to the stem cell harvest. If no values were obtained in the 3 months prior to the donation, provide and date the most recent values obtained prior to the stem cell harvest.

- | | Month | Day | Year | | | Specify units: |
|-----------|----------------------|----------------------|-------------------------|-----------------------------|----------------------|---|
| 84. Date: | <input type="text"/> | <input type="text"/> | 20 <input type="text"/> | 85. Hepatitis C viral load: | <input type="text"/> | 1 <input type="checkbox"/> log IU
2 <input type="checkbox"/> IU/mL |
| 86. Date: | <input type="text"/> | <input type="text"/> | 20 <input type="text"/> | 87. Hepatitis C viral load: | <input type="text"/> | 1 <input type="checkbox"/> log IU
2 <input type="checkbox"/> IU/mL |
| 88. Date: | <input type="text"/> | <input type="text"/> | 20 <input type="text"/> | 89. Hepatitis C viral load: | <input type="text"/> | 1 <input type="checkbox"/> log IU
2 <input type="checkbox"/> IU/mL |

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History of Antiviral Therapy for Hepatitis — Donor

90. Did the donor receive therapy for hepatitis prior to the stem cell harvest?

- 1 yes → **Continue with table below**
- 2 no → **Continue with question 110**

Therapy Given?	Date Started			Currently Receiving?	Therapy Stopped?	Date Stopped			Reason Stopped
	Month	Day	Year			Month	Day	Year	Code
91. Lamivudine				93. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	94. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	95. <input type="text"/>	<input type="text"/>	<input type="text"/>	96. <input type="text"/>
1 <input type="checkbox"/> yes →	92. <input type="text"/>	<input type="text"/>	<input type="text"/>						
2 <input type="checkbox"/> no									
97. Interferon				99. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	100. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	101. <input type="text"/>	<input type="text"/>	<input type="text"/>	102. <input type="text"/>
1 <input type="checkbox"/> yes →	98. <input type="text"/>	<input type="text"/>	<input type="text"/>						
2 <input type="checkbox"/> no									
103. Other antiviral therapy									
1 <input type="checkbox"/> yes →	104. Specify other therapy: _____								
2 <input type="checkbox"/> no	105. <input type="text"/>	<input type="text"/>	<input type="text"/>	106. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	107. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	108. <input type="text"/>	<input type="text"/>	<input type="text"/>	109. <input type="text"/>

Codes for Antiviral Therapy Stopped

- | | | | |
|----------------|----------------------------|----------------|------------------|
| 1 Planned stop | 2 Undesirable side effects | 3 Other reason | 4 Reason unknown |
|----------------|----------------------------|----------------|------------------|

110. Signed: _____

Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____