ERROR CORRECTION FORM

Sequence Number: | | | | | | | | | | | | | | |

CIBMTR Recipient ID: | | | | | | | | | | |

Initials: | |

Today's Date: Month | | Day | | 2 0 Year | | |

Infusion Date: Month | | Day | | 2 0 Year | | |

CIBMTR Center Number: | | | | | |

CIBMTR®
CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

Juvenile Myelomonocytic Leukemia (JMML / JCML) Post-HSCT Data

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number: | | | | | |

CIBMTR Recipient ID: | | | | | | | | | | |

Today's Date: Month | | Day | | 2 0 Year | | |

Date of HSCT for which this form is being completed: Month | | Day | | Year | | | |

HSCT type: ☐ autologous ☐ allogeneic, unrelated ☐ allogeneic, related ☐ syngeneic (identical twin)

Product type: ☐ marrow ☐ PBSC ☐ cord blood ☐ other product, specify: _____

Visit: ☐ 100 day ☐ 6 month ☐ 1 year ☐ 2 years ☐ > 2 years, specify: | |

To be completed in conjunction with a Form 2100 – 100 Days Post-HSCT Data, Form 2200 – Six Months to Two Years Post-HSCT Data, or Form 2300 – Yearly Follow-Up for Greater Than Two Years Post-HSCT Data. Information reported here should reflect the date of last contact as reported in the post-HSCT data collection form, or immediately prior to death.

1. What was the recipient's best response to transplant since the date of the last report?
   1 ☐ continued complete response (CCR) — continued absence of all known disease after a complete response to a previous line of therapy
   2 ☐ complete response (CR) — normalization of WBC and organomegaly
   3 ☐ partial response (PR) — ≥ 50% reduction in WBC and / or organomegaly
   4 ☐ marginal response (MR) — one of the following: between 25% and 50% reduction in WBC and organomegaly — or — partial response in WBC but no change in organomegaly — or — partial response in organomegaly but no change in WBC
   5 ☐ stable disease (SD) — ≤ 25% reduction in WBC and/or organomegaly
   6 ☐ progressive disease (PD) — increase in WBC and/or organomegaly
   7 ☐ not evaluable → 2. Specify reason: _____

3. Date of best response: Month | | Day | | Year | | | |

4. Did the recipient experience any skin involvement since the date of the last report?
   1 ☐ yes
   2 ☐ no
   3 ☐ unknown

5. Did the recipient receive GVHD prophylaxis since the date of the last report?
   1 ☐ yes →
   2 ☐ no
   3 ☐ unknown

   6. Start date: Month | | Day | | Year | | | | ☐ date previously reported

   7. Stop date: Month | | Day | | Year | | | | ☐ prophylaxis ongoing

8. Did the recipient receive planned 13-cis-retinoic acid (RA) therapy per protocol since the date of the last report?
   1 ☐ yes
   2 ☐ no
   3 ☐ unknown

CIBMTR Form 2115 (JMML) v1.0 (1–2) July 2007
Copyright © 2007 National Marrow Donor Program and The Medical College of Wisconsin, Inc. All rights reserved.
For internal use only: Document F00503 version 1.0 Replaces: n/a

Mail this form to your designated campus (Milwaukee or Minneapolis). Retain the original at the transplant center.

Fax this form to your designated campus (Milwaukee 414-456-6165 or Minneapolis 612-627-5895).

ERROR CORRECTION FORM

Sequence Number: | | | | | | | | | | | | | | |

CIBMTR Recipient ID: | | | | | | | | | | |

Initials: | |

Today's Date: Month | | Day | | | 2 0 | | | Year

Infusion Date: Month | | Day | | | 2 0 | | | Year

CIBMTR Center Number: | | | | | |

CIBMTR Center Number: | | | | | |

CIBMTR Recipient ID: | | | | | | | | | | |

9. What is the recipient's current disease status at the date of last contact? *(see response definitions in question 1)*

1 ☐ CCR
2 ☐ CR
3 ☐ persistent disease without progression (never CR post-HSCT)
4 ☐ PD (never CR post-HSCT) →
5 ☐ disease relapse after achieving CR post-HSCT →

10. Date of disease relapse / progression: Month | | Day | | Year | | | |

Specify site(s) of disease relapse / progression:

11. 1 ☐ yes 2 ☐ no Bone marrow
12. 1 ☐ yes 2 ☐ no Central nervous system
13. 1 ☐ yes 2 ☐ no Skin
14. 1 ☐ yes 2 ☐ no Other site → 15. Specify: _____

6 ☐ CR after post-HSCT relapse →

16. Date of disease relapse: Month | | Day | | Year | | | |

Specify treatment(s) given to achieve CR after post-HSCT relapse:

17. 1 ☐ yes 2 ☐ no Chemotherapy
18. 1 ☐ yes 2 ☐ no Donor leukocyte infusion (DLI)
19. 1 ☐ yes 2 ☐ no Second transplant →

A separate Form 2000 – Recipient Baseline Data must be completed for each infusion and for post-infusion events.

20. Date of CR: Month | | Day | | Year | | | |

7 ☐ not evaluable → 21. Specify: _____

22. Signed: _____
Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____

CIBMTR Form 2115 (JMML) v1.0 (2–2) July 2007
Copyright © 2007 National Marrow Donor Program and
The Medical College of Wisconsin, Inc. All rights reserved.
For internal use only: Document F00503 version 1.0 Replaces: n/a

Fax this form to your designated campus (Milwaukee 414-456-6165 or Minneapolis 612-627-5895).