Serological Evidence of Prior Hepatitis Exposure / Infection — Recipient

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

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

5. Date: Month Day Year
6. Hepatitis B viral load level: log IU/mL copies/mL pg/mL

7. Date: Month Day Year
8. Hepatitis B viral load level: log IU/mL copies/mL pg/mL

9. Date: Month Day Year
10. Hepatitis B viral load level: log IU/mL copies/mL pg/mL

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

11. Date: Month Day Year
12. Hepatitis C viral load: log IU/mL

13. Date: Month Day Year
14. Hepatitis C viral load: log IU/mL

15. Date: Month Day Year
16. Hepatitis C viral load: log IU/mL
17. Were any liver biopsies performed for cytology and/or pathology prior to HSCT?
   1 □ yes
   2 □ no

   Attach a copy of liver cytology / pathology report(s).

18. Did the recipient receive therapy for hepatitis prior to HSCT?
   1 □ yes
   2 □ no

   Continue with table below

<table>
<thead>
<tr>
<th>Therapy Given?</th>
<th>Date Started</th>
<th>Daily Dose</th>
<th>Reason Started</th>
<th>Therapy Stopped?</th>
<th>Date Stopped</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lamivudine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. First course</td>
<td></td>
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</tr>
<tr>
<td>1 □ yes</td>
<td>20.</td>
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<td>2</td>
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<tr>
<td>2 □ no</td>
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<tr>
<td>25. Second course</td>
<td></td>
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<tr>
<td>1 □ yes</td>
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<tr>
<td>2 □ no</td>
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<tr>
<td>31. Third course</td>
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<td></td>
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<tr>
<td>1 □ yes</td>
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<tr>
<td>2 □ no</td>
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<tr>
<td>Interferon</td>
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<tr>
<td>37. First course</td>
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<tr>
<td>1 □ yes</td>
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<td>2</td>
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<tr>
<td>2 □ no</td>
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<td>43. Second course</td>
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<td>1 □ yes</td>
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<tr>
<td>2 □ no</td>
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<td>49. Third course</td>
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<tr>
<td>1 □ yes</td>
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<td>2</td>
<td></td>
</tr>
<tr>
<td>2 □ no</td>
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<tr>
<td>Other antiviral therapy</td>
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<tr>
<td>55. Specify other antiviral therapy given:</td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Codes for Antiviral Therapy Started</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Prophylaxis</td>
</tr>
<tr>
<td>2 Empiric therapy due to suspected infection</td>
</tr>
<tr>
<td>3 Documented infection</td>
</tr>
<tr>
<td>4 Planned post-HSCT therapy</td>
</tr>
</tbody>
</table>

Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).
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.

- **78. Date:**
  - Month
  - Day
  - Year
  - Hepatitis B viral load level:
  - Specify units:
    - 1 log IU
    - 2 IU/mL
    - 3 copies/mL
    - 4 pg/mL

- **80. Date:**
  - Month
  - Day
  - Year
  - Hepatitis B viral load level:
  - Specify units:
    - 1 log IU
    - 2 IU/mL
    - 3 copies/mL
    - 4 pg/mL

- **82. Date:**
  - Month
  - Day
  - Year
  - Hepatitis B viral load level:
  - Specify units:
    - 1 log IU
    - 2 IU/mL
    - 3 copies/mL
    - 4 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.

- **84. Date:**
  - Month
  - Day
  - Year
  - Hepatitis C viral load:
  - Specify units:
    - 1 log IU
    - 2 IU/mL

- **86. Date:**
  - Month
  - Day
  - Year
  - Hepatitis C viral load:
  - Specify units:
    - 1 log IU
    - 2 IU/mL

- **88. Date:**
  - Month
  - Day
  - Year
  - Hepatitis C viral load:
  - Specify units:
    - 1 log IU
    - 2 IU/mL
**History of Antiviral Therapy for Hepatitis — Donor**

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

1. yes  
2. no

<table>
<thead>
<tr>
<th>Therapy Given?</th>
<th>Date Started</th>
<th>Currently Receiving?</th>
<th>Therapy Stopped?</th>
<th>Date Stopped</th>
<th>Reason Stopped</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lamivudine</td>
<td>Month Day Year</td>
<td>92. Month Day Year</td>
<td>Month Day Year</td>
<td>93. Month Day Year</td>
<td>94. Month Day Year</td>
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<tr>
<td>Interferon</td>
<td>Month Day Year</td>
<td>97. Month Day Year</td>
<td>Month Day Year</td>
<td>98. Month Day Year</td>
<td>99. Month Day Year</td>
</tr>
<tr>
<td>Other antiviral therapy</td>
<td>Month Day Year</td>
<td>103. Month Day Year</td>
<td>Month Day Year</td>
<td>104. Month Day Year</td>
<td>105. Month Day Year</td>
</tr>
</tbody>
</table>

**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: ____________________________