CIBMTR®
CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

Hepatitis Serology Pre-HSCT Data

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number:

CIBMTR Recipient ID:

Today's Date: Month Day 20 Year

Date of HSCT for which this form is being completed: Month Day 20 Year

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

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

Information for this report should come from an actual examination by the Transplant Center physician, or the physician who is following the recipient pre-HSCT, or abstraction of the recipient's medical records.

All questions refer to the period prior to the preparative regimen for the recipient's first HSCT.

Serological Evidence of Prior Hepatitis Exposure / Infection — Recipient

1. Specify and/or confirm previous hepatitis B surface antigen (HBsAg) testing performed and reported on the Form 2400 — Pre-Transplant Essential Data:
   1 ☐ positive
   2 ☐ negative
   3 ☐ inconclusive
   4 ☐ not tested

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.

Month Day Year

2. Date: 20
3. Hepatitis B viral load level: , .
4. Date: 20
5. Hepatitis B viral load level: , .
6. Date: 20
7. 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 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.

Month Day Year

8. Date: 20
9. Hepatitis C viral load: , , .
10. Date: 20
11. Hepatitis C viral load: , , .
12. Date: 20
13. Hepatitis C viral load: , , .

Specify units:
1 ☐ log IU
2 ☐ IU/mL

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

Internal use: Document number F00565 revision 2 Replaces: F00565 version 1.0 July 2007

CIBMTR Center Number: | | | | | | CIBMTR Recipient ID: | | | | | | | | | | |

14. 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

15. Did the recipient receive therapy for hepatitis prior to HSCT?
    1 ☐ yes → **Continue with table below**
    2 ☐ no → **Continue with question 71**

For the therapy table below, see "Reason Started" codes below. Therapy paused for < 1 week should *not* be considered as "Therapy Stopped."

Therapy Given?	Date Started (Month / Day / Year)	Daily Dose (mg)	Reason Started (Code)	Therapy Stopped?	Date Stopped (Month / Day / Year)
Lamivudine					
16. First course — 1 ☐ yes / 2 ☐ no	17.	18.	19.	20. 1 ☐ yes / 2 ☐ no	21.
22. Second course — 1 ☐ yes / 2 ☐ no	23.	24.	25.	26. 1 ☐ yes / 2 ☐ no	27.
28. Third course — 1 ☐ yes / 2 ☐ no	29.	30.	31.	32. 1 ☐ yes / 2 ☐ no	33.
Interferon					
34. First course — 1 ☐ yes / 2 ☐ no	35.	36.	37.	38. 1 ☐ yes / 2 ☐ no	39.
40. Second course — 1 ☐ yes / 2 ☐ no	41.	42.	43.	44. 1 ☐ yes / 2 ☐ no	45.
46. Third course — 1 ☐ yes / 2 ☐ no	47.	48.	49.	50. 1 ☐ yes / 2 ☐ no	51.
Other antiviral therapy					
52. Specify other antiviral therapy given: _____					
53. First course — 1 ☐ yes / 2 ☐ no	54.	55.	56.	57. 1 ☐ yes / 2 ☐ no	58.
59. Second course — 1 ☐ yes / 2 ☐ no	60.	61.	62.	63. 1 ☐ yes / 2 ☐ no	64.
65. Third course — 1 ☐ yes / 2 ☐ no	66.	67.	68.	69. 1 ☐ yes / 2 ☐ no	70.

Codes for Reason 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.

71. Hepatitis B core antibody (HBcAb) 1 ☐ positive 2 ☐ negative 3 ☐ inconclusive 4 ☐ not tested 5 ☐ confirm prior result
72. Hepatitis B surface antigen (HBsAg) 1 ☐ positive 2 ☐ negative 3 ☐ inconclusive 4 ☐ not tested 5 ☐ confirm prior result
73. Hepatitis B e antigen (HBeAg) 1 ☐ positive 2 ☐ negative 3 ☐ inconclusive 4 ☐ not tested
74. 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

75. Date: | | / | | / 2 0 | | 76. Hepatitis B viral load level: | | | , | | | . | | Specify units: 1 ☐ log IU 2 ☐ IU/mL 3 ☐ copies/mL 4 ☐ pg/mL

77. Date: | | / | | / 2 0 | | 78. Hepatitis B viral load level: | | | , | | | . | | 1 ☐ log IU 2 ☐ IU/mL 3 ☐ copies/mL 4 ☐ pg/mL

79. Date: | | / | | / 2 0 | | 80. Hepatitis B viral load level: | | | , | | | . | | 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.

Month Day Year

81. Date: | | / | | / 2 0 | | 82. Hepatitis C viral load: | | , | | | , | | | . | | Specify units: 1 ☐ log IU 2 ☐ IU/mL

83. Date: | | / | | / 2 0 | | 84. Hepatitis C viral load: | | , | | | , | | | . | | 1 ☐ log IU 2 ☐ IU/mL

85. Date: | | / | | / 2 0 | | 86. Hepatitis C viral load: | | , | | | , | | | . | | 1 ☐ log IU 2 ☐ IU/mL

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History of Antiviral Therapy for Hepatitis — Donor

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

1 ☐ yes → **Continue with table below**

2 ☐ no → **Continue with the signature lines at question 107**

Therapy Given?	Date Started (Month / Day / Year)	Currently Receiving?	Therapy Stopped?	Date Stopped (Month / Day / Year)	Reason Stopped (Code)
88. Lamivudine 1 ☐ yes →	89. ☐☐ / ☐☐ / ☐☐☐☐	90. 1 ☐ yes 2 ☐ no	91. 1 ☐ yes → 2 ☐ no	92. ☐☐ / ☐☐ / ☐☐☐☐	93. ☐
2 ☐ no					
94. Intreferon 1 ☐ yes →	95. ☐☐ / ☐☐ / ☐☐☐☐	96. 1 ☐ yes 2 ☐ no	97. 1 ☐ yes → 2 ☐ no	98. ☐☐ / ☐☐ / ☐☐☐☐	99. ☐
2 ☐ no					
100. Other antiviral therapy 1 ☐ yes →	101. Specify other therapy: _____				
2 ☐ no	102. ☐☐ / ☐☐ / ☐☐☐☐	103. 1 ☐ yes 2 ☐ no	104. 1 ☐ yes → 2 ☐ no	105. ☐☐ / ☐☐ / ☐☐☐☐	106. ☐

Codes for Reason Antiviral Therapy Stopped

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

107. Signed: _____

Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____

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