Acute Lymphoblastic Leukemia
Post-HSCT Data

Post-HSCT Planned Treatment for ALL

1. Was planned treatment given per protocol since the date of the last report? (Include any treatment given for maintenance therapy, but exclude any treatment for relapse / progressive disease.) □
   
   1 □ yes
   2 □ no

2. Central nervous system irradiation
   
   1 □ yes
   2 □ no

3. Systemic / intrathecal therapy
   
   1 □ yes
   2 □ no

   Specify systemic / intrathecal therapy given:
   
   4. 1 □ yes 2 □ no aldesleukin (interleukin-2, IL-2)
   5. 1 □ yes 2 □ no chemotherapy
   6. 1 □ yes 2 □ no dasatinib (Sprycel)
   7. 1 □ yes 2 □ no imatinib (Gleevec)
   8. 1 □ yes 2 □ no interferon-α (Referon-α)
   9. 1 □ yes 2 □ no intrathecal drugs
   10. 1 □ yes 2 □ no nilotinib (AMN107, Tasigna)
   11. 1 □ yes 2 □ no other therapy

12. Specify therapy:

13. Donor leukocyte infusions
   
   1 □ yes
   2 □ no

14. Other treatment
   
   1 □ yes
   2 □ no

15. Specify treatment: __________________________

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Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).
### Disease Assessment at the Time of Best Response to HSCT, Including Planned Therapy

16. Was a complete remission (CR) ever achieved in response to the HSCT? (Include any therapy planned as of Day 0, but exclude any change in therapy in response to a disease assessment.)

1. [ ] recipient was already in CR at the start of the preparative regimen
2. [ ] yes, post-HSCT CR was achieved
3. [ ] no, CR was never achieved post-HSCT

---

### Disease Relapse Post-HSCT

25. Has the disease relapsed since the date of the last report?

1. [ ] yes
2. [ ] no

---

### Specifying the Date of Clinical/Hematologic CR

17. Specify the date the clinical/hematologic CR was achieved:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

[ ] date previously reported

18. Did molecular testing confirm the presence of the CR?

1. [ ] yes
2. [ ] no
3. [ ] not tested

19. Date the molecular CR was determined:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

---

20. Did cytogenetic testing confirm the presence of the CR?

1. [ ] yes
2. [ ] no
3. [ ] not tested

21. Was FISH used to determine cytogenetic CR status?

1. [ ] yes
2. [ ] no

22. Date the cytogenetic CR was determined via FISH:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

23. Were conventional cytogenetics used to determine cytogenetic CR status?

1. [ ] yes
2. [ ] no

24. Date the cytogenetic CR was determined via conventional cytogenetics:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

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27. Date of the molecular assessment:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

28. Was there evidence of disease?

1. [ ] yes
2. [ ] no

29. Was the status considered a disease relapse or progression?

1. [ ] yes
2. [ ] no
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>30. Cytogenetic assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Was the disease assessed via FISH?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Date of FISH test:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. Was there evidence of disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. Was the status considered a disease relapse or progression?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. Was the disease assessed via conventional cytogenetics?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. Date of conventional cytogenetic test:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Was there evidence of disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. Was the status considered a disease relapse or progression?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. Clinical / hematologic assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. Date of the clinical / hematologic assessment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41. Was there evidence of disease?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Post-HSCT Treatment for ALL

42. Was any treatment given for relapsed, persistent, or progressive disease since the date of the last report?

1. yes
2. no

Specify treatment(s) given:

43. Central nervous system irradiation
   1. yes
   2. no

44. Systemic / intrathecal therapy
   1. yes
   2. no

Specify systemic / intrathecal therapy given:

45. 1. yes 2. no aldesleukin (interleukin-2, IL-2)
46. 1. yes 2. no chemotherapy
47. 1. yes 2. no dasatinib (Sprycel)
48. 1. yes 2. no imatinib (Gleevec)
49. 1. yes 2. no interferon-α (Referon-α)
50. 1. yes 2. no intrathecal drugs
51. 1. yes 2. no nilotinib (AMN107, Tasigna)
52. 1. yes 2. no other therapy

53. Specify therapy:

54. Donor leukocyte infusions
   1. yes
   2. no

55. Subsequent HSCT
   1. yes
   2. no

56. Other treatment
   1. yes
   2. no

Disease Status at the Time of Assessment for This Reporting Period

58. Was the disease status assessed since the date of the last report?

1. yes
2. no, is the same assessment as 25–41, as no treatment was given
3. no

Specify the method(s) used to assess the disease status:

59. Current molecular assessment
   1. yes
   2. no

60. Date of the molecular assessment:
   Month Day Year

61. Was there evidence of disease?

1. yes
2. no

62. Was the status considered a relapse or persistent disease?

1. yes
2. no

63. Current cytogenetic assessment
   1. yes
   2. no

64. Was the disease status assessed via FISH?

1. yes
2. no

65. Date of FISH test:
   Month Day Year

CIBMTR Form 2111 (ALL) v1.0 (4–5) July 2007
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### CIBMTR Form 2111 (ALL) v1.0 (5–5) July 2007

**CIBMTR Recipient ID:**

**CIBMTR Center Number:**

**Today's Date:** 20

**Infusion Date:** 20

**CIBMTR Center Number:**

**CIBMTR Recipient ID:**

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<th>CIBMTR Recipient ID</th>
<th>Visit</th>
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<tr>
<td></td>
<td></td>
<td>☐ 100 day</td>
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<td></td>
<td></td>
<td>☐ 6 month</td>
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<td>☐ year</td>
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</tbody>
</table>

**Today's Date:** 20

**Infusion Date:** 20

**CIBMTR Center Number:**

**CIBMTR Recipient ID:**

<table>
<thead>
<tr>
<th>Date of the clinical / hematologic assessment:</th>
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<tbody>
<tr>
<td>Month</td>
</tr>
<tr>
<td>20</td>
</tr>
</tbody>
</table>

**Date of conventional cytogenetic test:**

**Date of conventional cytogenetic test:** 20

### 72. Current clinical / hematologic assessment

<table>
<thead>
<tr>
<th>1</th>
<th>yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>no</td>
</tr>
</tbody>
</table>

### 66. Was there evidence of disease?

<table>
<thead>
<tr>
<th>1</th>
<th>yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>no</td>
</tr>
</tbody>
</table>

### 67. Was the status considered a relapse or persistent disease?

<table>
<thead>
<tr>
<th>1</th>
<th>yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>no</td>
</tr>
</tbody>
</table>

### 68. Was the disease status assessed via conventional cytogenetics?

<table>
<thead>
<tr>
<th>1</th>
<th>yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>no</td>
</tr>
</tbody>
</table>

### 69. Date of conventional cytogenetic test:

**Date of conventional cytogenetic test:** 20

**Month** | **Day** | **Year**
<table>
<thead>
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</tbody>
</table>

### 70. Was there evidence of disease?

<table>
<thead>
<tr>
<th>1</th>
<th>yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>no</td>
</tr>
</tbody>
</table>

### 71. Was the status considered a relapse or persistent disease?

<table>
<thead>
<tr>
<th>1</th>
<th>yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>no</td>
</tr>
</tbody>
</table>

### 75. What is the current disease status?

<table>
<thead>
<tr>
<th>1</th>
<th>complete remission</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>not in complete remission</td>
</tr>
</tbody>
</table>

### 76. Date the current disease status was established in this reporting period:

**Date the current disease status was established in this reporting period:** 20

**Month** | **Day** | **Year**
<table>
<thead>
<tr>
<th></th>
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</tbody>
</table>

### 77. Signed:

**Person completing form**

Please print name: ____________________________

Phone number: ( ) ____________________________

Fax number: ( ) ____________________________

E-mail address: ____________________________

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