<table>
<thead>
<tr>
<th>Key Fields</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sequence Number:</strong></td>
</tr>
<tr>
<td><strong>Date Received:</strong></td>
</tr>
<tr>
<td><strong>CIBMTR Center Number:</strong></td>
</tr>
<tr>
<td><strong>CIBMTR Recipient ID:</strong></td>
</tr>
<tr>
<td><strong>Today's Date:</strong></td>
</tr>
<tr>
<td><strong>Date of HSCT for which this form is being completed:</strong></td>
</tr>
<tr>
<td><strong>HSCT type:</strong> (check all that apply)</td>
</tr>
<tr>
<td>Autologous</td>
</tr>
<tr>
<td>Allogeneic, unrelated</td>
</tr>
<tr>
<td>Allogeneic, related</td>
</tr>
<tr>
<td>Syngeneic (identical twin)</td>
</tr>
</tbody>
</table>

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 414-805-0714 or Minneapolis 612-627-5895).
CIBMTR Center Number: __________________ CIBMTR Recipient ID: __________________________

Syngeneic (identical twin)
ELSE GOTO Marrow

Product Type (check all that apply):
☐ Marrow
ELSE GOTO PBSC

☐ PBSC
ELSE GOTO Cord blood

☐ Cord blood
ELSE GOTO Other product

☐ Other product
IF Other product:= checked
THEN GOTO Specify:
ELSE GOTO Visit:

Specify: ______________________
ELSE GOTO Visit:

Visit:
O 100 day
O 6 months
O 1 year
O 2 years
O > 2 years,
IF Visit::= > 2 years,
THEN GOTO Specify:
ELSE GOTO (1) Best response

Specify: _______ _______ _______ _______
ELSE GOTO (1) Best response

Disease Assessment at the Time of Best Response to HSCT
Questions: 1-2

To be completed in conjunction with a Form 2100 - 100 Days Post-HSCT Data, Form 2200 - Six Months to Two Years Post-HSCT, 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.

Best response is based on response to the HSCT, but does NOT include response to any therapy given for disease relapse or progression post-HSCT. When determining the best response to HSCT, compare the post-HSCT disease status to the status immediately prior to the preparative regimen, regardless of time since HSCT. This comparison is meant to capture the BEST disease status in response to HSCT that occurred in the reporting interval, even if a subsequent disease relapse or progression occurred during the same reporting interval. If a recipient already

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achieved their best response in a previous reporting interval, confirm the best response and check the box to indicate “date previously reported”.  

1 Compared to the disease status prior to the preparative regimen, what was the best response to HSCT since the date of the last report? (include any therapy planned as day 0, but exclude any change in therapy in response to disease assessment.)

- **O** complete remission (CR) - requires all of the following, maintained for >=4 weeks: • bone marrow evaluation: < 5% myeloblasts with normal maturation of all cell lines • peripheral blood evaluation: hemoglobin >= 11g/dL untransfused and without erythropoietin support; ANC >= 1000 / mm$^3$ without myeloid growth factor support; platelets >= 100,000 / mm$^3$ without thrombopoietic support; 0% blasts

- **O** hematologic improvement (HI) - requires one measurement of the following, maintained for >= 8 weeks without ongoing cytotoxic therapy: • HI-E - hemoglobin increase of >=1.5 g/dL untransfused; for RBC transfusions performed for Hgb <=9.0, reductions in RBC units transfused in 8 weeks by >=4 units compared to the pre-treatment transfusion number in the previous 8 weeks • HI-P - for pre-treatment platelet count of > 20,000 / mm$^3$, platelet absolute increase of >= 30,000 / mm$^3$; for pre-treatment platelet count of < 20,000 / mm$^3$, platelet absolute increase of >=20,000 / mm$^3$ and >= 100% from pre-treatment level • HI-N - neutrophil count increase of >=100% from pre-treatment level and an absolute increase of > -500 / mm$^3$

- **O** no response (NR) / stable disease (SD) - does not meet the criteria for at least HI, but no evidence of disease progression

- **O** progression from hematologic improvement (prog from HI) - requires at least one of the following, in the absence of another explanation (e.g., infection, bleeding, ongoing chemotherapy, etc.): • >=50% reduction from maximum response levels in granulocytes or platelets • reduction in hemoglobin by >= 1.5 g/dL • transfusion dependence

- **O** relapse from complete remission (rel from CR) - requires at least one of the following: • return to pre-treatment bone marrow blast percentage • decrease of > 50% from maximum response levels in granulocytes or platelets • transfusions dependence, or hemoglobin level >= 1.5 g/dL lower that prior to therapy

- **O** progression to AML - >= 20% blasts in the bone marrow

ELSE GOTO (2) date of best response was previously reported

2 **☐** date of best response was previously reported

  IF (2) date of best response was previously reported:= checked

  THEN GOTO (3) Was a disease relapse or progression detected by any method since the date of the last report?

  ELSE GOTO Date best response first began:

  Date best response first began:       YYYY    MM    DD

  ELSE GOTO (3) Was a disease relapse or progression detected by any method since the date of the last report?

3 Was a disease relapse or progression detected by any method since the date of the last report?

  **O** yes

  **O** no

  IF (3) Was a disease relapse or progression detected by any method since the date of the last report?= yes

  THEN GOTO (4) Date the disease relapse or progression was established in this reporting period:

  ELSE GOTO (5) Was the bone marrow examined (post-HSCT) since the date of the last report?

  **☐** Date the disease relapse or progression was established in this reporting period:

  YYYY    MM    DD

  ELSE GOTO (5) Was the bone marrow examined (post-HSCT) since the date of the last report?
### Most Recent Laboratory Studies

**Questions: 5-11**

1. **5** Was the bone marrow examined (post-HSCT) since the date of the last report?
   - **O** yes
   - **O** no

   **IF (5) Was the bone marrow examined (post-HSCT) since the date of the last report?:= yes**
   **THEN GOTO (6) Date of bone marrow exam:**
   **ELSE GOTO (12) What is the current disease status?**

2. **6** Date of bone marrow exam: ___ ___ ___ ___ ___ ___ ___ ___

   **ELSE GOTO (7) Blasts in marrow:**

3. **7** Blasts in marrow:
   - **O** known
   - **O** not known

   **IF (7) Blasts in marrow::= known**
   **THEN GOTO (8) blasts in bone marrow**
   **ELSE GOTO (9) Did the recipient have myelofibrosis since the date the last report?**

4. **8** ___________ ___________ ___________ ___________ ___________ ___________ ___________ %

   **ELSE GOTO (9) Did the recipient have myelofibrosis since the date the last report?**

5. **9** Did the recipient have myelofibrosis since the date the last report?
   - **O** yes
   - **O** no

   **IF (9) Did the recipient have myelofibrosis since the date the last report?:= yes**
   **THEN GOTO (10) Specify the status of marrow fibrosis since the date of the last report:**
   **ELSE GOTO (11) Is a copy of the bone marrow lab report attached?**

6. **10** Specify the status of marrow fibrosis since the date of the last report:
   - **O** unchanged / more severe
   - **O** improved
   - **O** resolved
   - **O** unknown

   **ELSE GOTO (11) Is a copy of the bone marrow lab report attached?**

7. **11** Is a copy of the bone marrow lab report attached?
   - **O** yes
   - **O** no

   **ELSE GOTO (12) What is the current disease status?**

### Disease Status at the Time of Assessment for this Reporting Period

**Questions: 12-13**

1. **12** What is the current disease status?
   - **O** complete remission

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CIBMTR Form 2114 revision 2 (page 4 of 5) Last Updated November 12, 2012.
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O not in complete remission

ELSE GOTO (13) Date the current disease status was established in this reporting period:

13 Date the current disease status was established in this reporting period: __-YYYY-MM-DD__

ELSE GOTO First name

First Name: ______________________

ELSE GOTO Last name

Last Name: ______________________

ELSE GOTO Phone number:

Phone number: ______________________

ELSE GOTO Fax number:

Fax number: ______________________

ELSE GOTO E-mail address:

E-mail address: ______________________

ELSE GOTO End of Form