### Key Fields

<table>
<thead>
<tr>
<th>Sequence Number:</th>
<th>__ __ __ __</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Received:</td>
<td>__ __ __ __</td>
</tr>
<tr>
<td>CIBMTR Center Number:</td>
<td>__ __ __ __</td>
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<tr>
<td>CIBMTR Recipient ID:</td>
<td>__ __ __ __</td>
</tr>
<tr>
<td>Today's Date:</td>
<td>__ __ __ __</td>
</tr>
<tr>
<td>Date of HSCT for which this form is being completed:</td>
<td>__ __ __ __</td>
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</tbody>
</table>

**HSCT Type (check all that apply):**

- Autologous
- Allogeneic, unrelated
- Allogeneic, related
- Syngeneic (identical twin)

**Product Type (check all that apply):**

- Marrow
- PBSC
- Cord blood
- Other product

Specify: ___________________________________________________________________

**Visit:**

- 100 day
- 6 months
- 1 year
- 2 years
- > 2 years, Specify: ___________________________________________________________________
Disease Assessment at the Time of Best Response to HSCT

1. Specify the percent of clinical improvement at the time of best response since HSCT compared to the evaluation just prior to mobilization, according to American College of Rheumatology (ACR) criteria:


   Requires 20%* or more improvement in 3 of following 6 criteria, with no more than 1 of the remaining variables worsened by more than 30%*:
   - physician global assessment of disease activity
   - parent/recipient global assessment of overall well-being
   - functional ability
   - number of joints with active arthritis
   - number of joints with limited range of motion
   - erythrocyte sedimentation rate (ESR)

   *Substitute 50% or 70% for 50% and 70% improvement levels, respectively.

   - disease is worse
   - no improvement
   - 20% improvement (ACR20)
   - 50% improvement (ACR50)
   - 70% improvement (ACR70)
   - disease in remission

2. Date of assessment for best response: __ __ __ __

3. Specify the date of disease progression: __ __ __ __

4. Specify the date of maximal improvement: __ __ __ __

5. Specify the date of disease remission: __ __ __ __

Post-HSCT Treatment for Juvenile Idiopathic Arthritis

6. Did the recipient receive any treatment for JIA/JRA since the date of the last report?

   - yes
   - no
   - Unknown

7. Were corticosteroid therapy given?

   - yes
   - no
   - Unknown

8. Reason for therapy:

   - Planned per protocol
   - Continued from prior to HSCT
   - Relapse / progression of RA
   - Other reason
   - Reason unknown

9. Specify other reason: ________________________________

10. Date Therapy Started: __ __ __ __
Form 2142 R2.0: Juvenile Idiopathic Arthritis Post-HSCT Data

Center: CRID:

11 Currently Receiving?
   yes    no

12 Was cyclophosphamide (CTX, Cytoxan, Neosar) therapy given?
   yes    no    Unknown

13 Reason for therapy:
   planned per protocol
   continued from prior to HSCT
   relapse / progression of JRA
   other reason
   reason unknown

14 Specify other reason: ______________________

15 Date Therapy Started: __ __ __ __ - __ __ - __ __

16 Currently Receiving?
   yes    no

17 Was cyclosporine (CsA, Neoral, Sandimmune) therapy given?
   yes    no    Unknown

18 Reason for therapy:
   planned per protocol
   continued from prior to HSCT
   relapse / progression of JRA
   other reason
   reason unknown

19 Specify other reason: ______________________

20 Date Therapy Started: __ __ __ __ - __ __ - __ __

21 Currently Receiving?
   yes    no

22 Was etanercept (Enbrel) therapy given?
   yes    no    Unknown
23 Reason for therapy:
- planned per protocol
- continued from prior to HSCT
- relapse / progression of JRA
- other reason
- reason unknown

24 Specify other reason: _______________________

25 Date Therapy Started: __ __ __ __ - __ __ - __ __

26 Currently Receiving?
- yes  
- no  

27 Was methotrexate (MTX, Folex) therapy given?
- yes  
- no  
- Unknown

28 Reason for therapy:
- planned per protocol
- continued from prior to HSCT
- relapse / progression of JRA
- other reason
- reason unknown

29 Specify other reason: _______________________

30 Date Therapy Started: __ __ __ __ - __ __ - __ __

31 Currently Receiving?
- yes  
- no  

32 Were non-steroidal anti-inflammatory drugs (NSAIDS) therapy given?
- yes  
- no  
- Unknown

33 Reason for therapy:
- planned per protocol
- continued from prior to HSCT
- relapse / progression of JRA
- other reason
- reason unknown

34 Specify other reason: _______________________

35 Date Therapy Started: __ __ __ __ - __ __ - __ __
36 Currently Receiving?
   yes  no

37 Was any other treatment given?
   yes  no  Unknown

38 Reason for therapy:
   planned per protocol
   continued from prior to HSCT
   relapse / progression of JRA
   other reason
   reason unknown

39 Specify other reason:

40 Date Therapy Started: __ __ __ __ - __ __

41 Currently Receiving:
   yes  no

42 Specify other treatment:

Disease Status at the Time of Assessment for This Reporting Period

43 Date of assessment for the current disease evaluation: __ __ __ __

44 Specify the number of painful / tender joints since the date of the last report:
   number unknown

45 Specify the number of swollen / effused joints since the date of the last report:
   number unknown

46 Specify the Pediatric EPM Range of Motion final score (0.0 - 3.0):
   Pediatric EPM Range of Motion final score unknown

47 Was morning stiffness present since the date of the last report?
   yes  no  Unknown

48 Specify the duration of morning stiffness: _______________________

49 Specify the recipient's current height:
   Known  Unknown

50 Recipient's current height: ________________________
   in  cm
51 Specify the recipient's current weight:

| Known | Unknown |

52 Recipient's current weight: ____________________________ lbs  kg

53 Specify if any of the following laboratory values were elevated since the date of the last report:

54 Erythrocyte sedimentation rate (ESR)

| yes | no | Unknown |

Laboratory Studies for This Reporting Period

Questions: 53 - 63
Radiographic Assessment for This Reporting Period

Questions: 64 - 67

64 Were radiographic bone erosions present since the date of the last report?
- yes
- no
- Unknown

65 Was advanced skeletal age of affected joints noted radiographically since the date of the last report?
- yes
- no
- Unknown

66 Was osteoporosis present since the date of the last report?
- yes
- no
- Unknown

67 Were osteoporotic fractures present?
- yes
- no
- Unknown

Functional Assessment for This Reporting Period

Questions: 68 - 85

70 Did the recipient complete a Childhood Health Assessment Questionaire (CHAQ) since the date of the last report?
- yes
- no
- Unknown

Specify the following scores for the CHAQ pain sub-scale:

69 Recipient's pain assessment: __________________________

71 Best possible pain score: __________________________

Specify the following scores for the CHAQ disability sub-scale:

72 Recipient's disability assessment: __________________________

74 Best possible disability score: __________________________

Specify the following scores for the CHAQ severity sub-scale:

75 Recipient's severity assessment: __________________________

77 Best possible severity score: __________________________

78 Did the physician complete a Global Assessment of Functioning of the recipient's health since the date of the last report?
- yes
- no
- Unknown

79 Physician-rated Global Assessment score: __________________________

81 Best possible score: __________________________
Specify the percent of clinical improvement since the time of the last report, according to American College of Rheumatology (ACR) criteria:


Requires 20%* or more improvement in 3 of following 6 criteria, with no more than 1 of the remaining variables worsened by more than 30%*:

- physician global assessment of disease activity
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*Substitute 50% or 70% for 50% and 70% improvement levels, respectively.

disease is worse
no improvement
20% improvement (ACR20)
50% improvement (ACR50)
70% improvement (ACR70)
disease in remission

Specify the date of disease progression: __ __ __ __ - __ __ __ __

Specify the date of maximal improvement: __ __ __ __ - __ __ __ __

Specify the date of disease remission: __ __ __ __ - __ __ __ __

First Name: ________________________  Last Name: ________________________

Phone number: ________________________  Fax number: ________________________

E-mail address: ________________________

Mail, fax or email this form to Minneapolis. Fax: 612-627-5895. Email: scanform@nmdp.org. Retain the original form at the transplant center.