CIBMTR
CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

EBMT
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European Group for Blood and Marrow Transplantation

Multiple Sclerosis Post-HSCT Data

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number:

CIBMTR Recipient ID:

EBMT Center Identification Code (CIC):

Today's Date: Month Day Year 2 0

Date of HSCT for which this form is being completed: 🕮 Month Day Year 2 0

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

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

Visit: ☐ 100 day ☐ 6 month ☐ 1 year ☐ 2 years ☐ > 2 years, specify:

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

1. Date of actual contact with the recipient to determine medical status for this follow-up report: 🕮 Month Day Year

Disease Relapses or Progression of Disability Post-HSCT

2. Were there any relapses of multiple sclerosis (MS) since the date of the last report? 🕮
   1 ☐ yes →
   2 ☐ no

   3. Specify the date of first relapse since the date of the last report: Month Day Year

   4. Specify the number of relapses since the date of the last report: ☐ number unknown

5. Did the recipient experience continuous progression of MS since the date of the last report?
   1 ☐ yes
   2 ☐ no
   3 ☐ unknown

6. Was a MRI scan of the brain performed since the date of the last report?
   1 ☐ yes →
   2 ☐ no
   3 ☐ unknown

   7. Date of most recent MRI: Month Day Year ☐ date unknown

   8. Was disease relapse / progression detected on the MRI findings?
      1 ☐ yes →
      2 ☐ no

      Specify which MRI findings indicated disease relapse / progression:

      9. 1 ☐ yes 2 ☐ no 3 ☐ unknown New gadolinium-enhancing lesions

      10. 1 ☐ yes 2 ☐ no 3 ☐ unknown Enlarging T2 lesions

      11. 1 ☐ yes 2 ☐ no 3 ☐ unknown Radiology report states worsening of MS associated findings

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12. Were the Kurtzke Functional Systems Scores (FSS) assessed by a neurologist since the date of the last report?

1 ☐ yes → Specify the following FSS scores:
2 ☐ no
3 ☐ unknown

13. Pyramidal: ☐ score unknown
14. Cerebellar: ☐ score unknown
15. Brainstem: ☐ score unknown
16. Sensory: ☐ score unknown
17. Bowel and bladder: ☐ score unknown
18. Visual: ☐ score unknown
19. Cerebral: ☐ score unknown
20. Other function: 21. Specify other function: _____ ☐ score unknown

22. Specify the Kurtzke Expanded Disability Status Scale (EDSS): | | . | | ☐ EDSS unknown

23. Specify date of EDSS assessment: | | (Month) | | | (Day) | | | | (Year) ☐ date unknown

Post-HSCT Treatment for Multiple Sclerosis

24. Did the recipient receive any treatment for MS since the date of the last report?

1 ☐ yes → **Continue with questions below**
2 ☐ no →
3 ☐ unknown → **Continue with the signature lines at question 59**

Specify the reason(s) for initiating post-HSCT therapy:

25. 1 ☐ yes 2 ☐ no Continued therapy from pre-HSCT
26. 1 ☐ yes 2 ☐ no Planned therapy per protocol
27. 1 ☐ yes 2 ☐ no Disease relapse
28. 1 ☐ yes 2 ☐ no Disease progression
29. 1 ☐ yes 2 ☐ no Other reason → 30. Specify other reason for initiating therapy: _____

31. What was the date the first therapy started? | | | | | | | | | | (Month) (Day) (Year)

Indicate all treatments for MS that the recipient received since the date of the last report:

32. 1 ☐ yes 2 ☐ no 3 ☐ unknown Alemtuzumab (Campath)
33. 1 ☐ yes 2 ☐ no 3 ☐ unknown Azathioprine (Azasan, Imuran)
34. 1 ☐ yes 2 ☐ no 3 ☐ unknown Belimumab (LymphoStat-B)
35. 1 ☐ yes 2 ☐ no 3 ☐ unknown Cladribine (2-CdA, Leustatin)
36. 1 ☐ yes 2 ☐ no 3 ☐ unknown Corticosteroids 🕮 (chronic use, not to treat acute relapse)
37. 1 ☐ yes 2 ☐ no 3 ☐ unknown Corticosteroids 🕮 (to treat acute relapse)
38. 1 ☐ yes 2 ☐ no 3 ☐ unknown Cyclophosphamide (CTX, Cytoxan, Neosar)
39. 1 ☐ yes 2 ☐ no 3 ☐ unknown Daclizumab (Zenapax, anti-CD25)

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40. 1 ☐ yes 2 ☐ no 3 ☐ unknown Fingolimod (FTY720)
41. 1 ☐ yes 2 ☐ no 3 ☐ unknown Fumarate (oral) (BG00012)
42. 1 ☐ yes 2 ☐ no 3 ☐ unknown Glatiramer acetate (Copaxone) [previously copolymer-1]
43. 1 ☐ yes 2 ☐ no 3 ☐ unknown Immune globulin (IVIG, Gamimune, Gammagard)
44. 1 ☐ yes 2 ☐ no 3 ☐ unknown Interferon beta-1a (Avonex, Rebif)
45. 1 ☐ yes 2 ☐ no 3 ☐ unknown Interferon beta-1b (Betaseron)
46. 1 ☐ yes 2 ☐ no 3 ☐ unknown Laquinimod
47. 1 ☐ yes 2 ☐ no 3 ☐ unknown Methotrexate (MTX, Folex)
48. 1 ☐ yes 2 ☐ no 3 ☐ unknown Mitoxantrone (Novantrone)
49. 1 ☐ yes 2 ☐ no 3 ☐ unknown Mycophenolate mofetil (MMF, Cellcept)
50. 1 ☐ yes 2 ☐ no 3 ☐ unknown Natalizumab (Tysabri, Antegren)
51. 1 ☐ yes 2 ☐ no 3 ☐ unknown Rituximab (anti-CD20, Rituxan, MabThera)
52. 1 ☐ yes 2 ☐ no 3 ☐ unknown Sirolimus (Rapamune)
53. 1 ☐ yes 2 ☐ no 3 ☐ unknown Tacrolimus (FK 506, Prograf)
54. 1 ☐ yes 2 ☐ no 3 ☐ unknown Teriflunomide (oral) (HMR1726)
55. 1 ☐ yes 2 ☐ no 3 ☐ unknown Blinded randomized trial agent → 56. Specify trial agent: _____
57. 1 ☐ yes 2 ☐ no 3 ☐ unknown Other treatment → 58. Specify other treatment: _____

If the person completing this form is a Neurologist, check here ☐ and continue with the signautre lines below.

59. Signed: _____
Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____

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