Form 2400 R5.0: Pre-Transplant Essential Data

Center: CRID:

Key Fields

OMB No: 0915-0310
Expiration Date: 1/31/2017

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Questions 347 – 357 are optional for non-U.S. centers

Recipient Data

Recipients are defined as all patients who have a CBU unit transfused during the study period. Include both clinical and non-clinical recipients.

Date of birth: __ __ __ __
Sex: □ male □ female
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Not applicable (not a resident of the USA) □ Unknown
Race (1)
Zip or postal code for place of recipient’s residence: (USA recipients only)
Is the recipient participating in a clinical trial?
□ yes □ no
Clinical Trials (1)
Sponsor
Specify other sponsor:
Study ID Number
Subject ID:

Hematopoietic Cellular Transplant (HCT)

Date of this HCT: __ __ __ __
Was this the first HCT for this recipient?
□ yes □ no
Is a subsequent HCT planned as part of the overall treatment protocol (not as a reaction to post-HCT disease assessment)? (For autologous HCTs only)
□ yes □ no
Specify subsequent HCT planned
□ Autologous □ Alogeneic
Specify the number of prior HCTs:

Mail, fax or email this form to Minneapolis. Fax: 612-527-5895. Email: scanform@nmdp.org.
Retain the original form at the transplant center.

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**Form 2400 R5.0: Pre-Transplant Essential Data**

**Center:**

**Key Fields**

- **Sequence Number:**
- **Date Received:** __ __ __ __ - __ __- __ __
- **CIBMTR Center Number:**
- **EBMT Code...**

**Optional for non-U.S. Centers**

Questions 347 – 357 are optional for non-U.S. centers.

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**Specify the HSC source(s) for all prior HCTs:**

16. Autologous
   - yes
   - no

17. Allogeneic, unrelated
   - yes
   - no

18. Allogeneic, related
   - yes
   - no

19. Syngeneic
   - yes
   - no

---

20. Date of the last HCT (just before current HCT) __ __ __ __ - __ __- __ __

21. Was the last HCT performed at a different institution?
   - yes
   - no

---

**Specify the institution that performed the last HCT:**

22. Name: ____________________________

23. What was the HSC source for the last HCT?
   - Autologous
   - Allogeneic, unrelated donor
   - Allogeneic, related donor

---

24. Reason for current HCT

25. Date of graft failure / rejection: __ __ __ __ - __ __- __ __

26. Date of relapse: __ __ __ __ - __ __- __ __

27. Date of secondary malignancy: __ __ __ __ - __ __- __ __

28. Specify other reason: ____________________________

---

**Donor Information**

Questions: 29 - 63

29. Multiple donors?
   - yes
   - no

30. Specify number of donors: ____________________________

---

**Donor Information for this HCT (1)**

Questions: 31 - 63

31. Specify donor

32. NMDP cord blood unit ID: ____________________________

33. NMDP donor ID: ____________________________

34. Non-NMDP unrelated donor ID: (not applicable for related donors) ____________________________

35. Non-NMDP cord blood unit ID: (include related and autologous CBUs) ____________________________

36. Is the CBU ID also the ISBT DIN number?
   - yes
   - no

37. Specify the ISBT DIN number: ____________________________

38. Registry or UCB Bank ID ____________________________

39. Specify other Registry or UCB Bank: ____________________________

40. Specify the related donor type
   - Syngeneic (monozygotic twin)
   - HLA-identical sibling (may include non-monozygotic twin)
   - HLA-matched other relative
   - HLA-mismatched relative

41. Date of birth (donor / infant)
   - Known
   - Unknown

42. Date of birth (donor / infant) __ __ __ __ - __ __- __ __

43. Age (donor / infant)
   - Known
   - Unknown
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**Center:**

**CRID:**

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**44** Age: (donor / infant) _____________

- Months (use only if less than 1 year old)
- years

**45** Sex (donor / infant)

- male
- female

**Specify product type:**

**46** Bone marrow

- yes
- no

**47** PBSC

- yes
- no

**48** Single cord blood unit

- yes
- no

**49** Other product

- yes
- no

**50** Specify other product type:

A series of collections should be considered a single product when they are all from the same donor and use the same collection method and technique (and mobilization, if applicable), even if the collections are performed on different days.

**51** Specify number of products infused from this donor: _________________

**52** Specify the number of these products intended to achieve hematopoietic engraftment: _________________

**Questions 53 – 60 are for autologous HCT recipients only. If other than autologous skip to question 61**

**53** Did the recipient have more than one mobilization event to acquire cells for HCT?

- yes
- no

**54** Specify the total number of mobilization events performed for this HCT: (regardless of the number of collections or which collections were used for this HCT) _________________

**Specify all agents used in the mobilization events reported above:**

**55** G-CSF

- yes
- no

**56** GM-CSF

- yes
- no

**57** Pegylated G-CSF

- yes
- no

**58** Plerixafor (Mozobil)

- yes
- no

**59** Other CXCR4 inhibitor

- yes
- no

**60** Combined with chemotherapy

- yes
- no

**61** Was this donor used for any prior HCTs?

- yes
- no

**62** Donor CMV-antibodies (IgG or Total) (Allogeneic HCTs only)

- Reactive
- Non-reactive
- Not done
- Not applicable (cord blood unit)

**63** Was plerixafor (Mozobil) given at any time prior to the preparative regimen? (Related HCTs only)

- yes
- no
- Unknown

---

**Consent**

**Questions: 64 - 71**
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64 Has the recipient signed an IRB-approved consent form for submitting research data to the NMDP / CIBMTR?
   ☐ Yes (patient consented)
   ☐ No (patient declined)
   ☐ Not approached

65 Date form was signed: __ __ __ __ - __ __- __ __

66 Did the recipient give permission to be directly contacted for future research?
   ☐ Yes (patient provided permission)
   ☐ No (patient declined)
   ☐ Not approached

67 Date form was signed: __ __ __ __ - __ __- __ __

68 Has the recipient signed an IRB-approved consent form to donate research blood samples to the NMDP / CIBMTR?
   ☐ Yes (patient consented)
   ☐ No (patient declined)
   ☐ Not approached
   ☐ Not applicable (center not participating)

69 Date form was signed: __ __ __ __ - __ __- __ __

70 Has the donor signed an IRB-approved consent form to donate research blood samples to the NMDP / CIBMTR? (Allogeneic donors only)
   ☐ Yes (donor consented)
   ☐ No (donor declined)
   ☐ Not approached
   ☐ Not applicable (center not participating)

71 Date form was signed: __ __ __ __ - __ __- __ __

Product Processing / Manipulation

Questions: 72 - 90

72 Was the product manipulated prior to infusion?
   ☐ yes ☐ no

73 Specify portion manipulated
   ☐ entire product ☐ portion of product

   Specify all methods used to manipulate the product:

74 Washed
   ☐ yes ☐ no

75 Diluted
   ☐ yes ☐ no

76 Buffy coat enriched (buffy coat preparation)
   ☐ yes ☐ no

77 B-cell reduced
   ☐ yes ☐ no

78 CD8 reduced
   ☐ yes ☐ no

79 Plasma reduced (removal)
   ☐ yes ☐ no

80 RBC reduced
   ☐ yes ☐ no

81 Cultured (ex-vivo expansion)
   ☐ yes ☐ no

82 Genetic manipulation (gene transfer / transduction)
   ☐ yes ☐ no

83 PUVA treated
   ☐ yes ☐ no

84 CD34 enriched (CD34+ selection)
   ☐ yes ☐ no
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**Clinical Status of Recipient Prior to the Preparative Regimen (Conditioning)**

Questions: 91 - 94

91 What scale was used to determine the recipient’s functional status?
- Karnofsky (recipient age ≥ 16 years)
- Lansky (recipient age < 16 years)

92 Karnofsky Scale (recipient age ≥ 16 years)
93 Lansky Scale (recipient age < 16 years)
94 Recipient CMV-antibodies (IgG or Total)
- Reactive
- Non-reactive
- Not done

**Comorbid Conditions**

Questions: 95 - 155

95 Is there a history of mechanical ventilation?
- yes
- no

96 Is there a history of proven invasive fungal infection?
- yes
- no

97 Were there clinically significant co-existing diseases or organ impairment at time of patient assessment prior to preparative regimen? Source: Blood, 2005 Oct 15;106(8):2912-2919
- yes
- no

98 Arrhythmia - For example, any history of atrial fibrillation or flutter, sick sinus syndrome, or ventricular arrhythmias requiring treatment
- yes
- no

99 Cardiac - Any history of coronary artery disease (one or more vessel-coronary artery stenosis requiring medical treatment, stent, or bypass graft), congestive heart failure, myocardial infarction, OR ejection fraction ≤ 50% on the most recent test
- yes
- no

100 Cerebrovascular disease - Any history of transient ischemic attack, subarachnoid hemorrhage or cerebrovascular accident
- yes
- no

101 Diabetes - Requiring treatment with insulin or oral hypoglycemics in the last 4 weeks but not diet alone
- yes
- no

102 Heart valve disease - Except asymptomatic mitral valve prolapse
- yes
- no

103 Hepatic, mild - Chronic hepatitis, bilirubin > upper limit of normal to 1.5 x upper limit of normal, or AST/ALT > upper limit of normal to 2.5 x upper limit of normal at the time of transplant OR any history of hepatitis B or hepatitis C infection
- yes
- no

104 Hepatic, moderate / severe - Liver cirrhosis, bilirubin > 1.5 x upper limit of normal, or AST/ALT > 2.5 x upper limit of normal
- yes
- no

105 Infection - For example, documented infection, fever of unknown origin, or pulmonary nodules requiring continuation of antimicrobial treatment after day 0
- yes
- no

106 Inflammatory bowel disease - Any history of Crohn’s disease or ulcerative colitis requiring treatment
- yes
- no

107 Obesity - Patients with a body mass index > 35 kg/m² prior to the start of conditioning
- yes
- no
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**Center:**

**CRID:**

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108 Peptic ulcer - Any history of peptic ulcer confirmed by endoscopy and requiring treatment
- **yes**
- **no**
  - **Unknown**

109 Psychiatric disturbance - For example, depression, anxiety, bipolar disorder or schizophrenia requiring psychiatric consult or treatment in the last 4 weeks
- **yes**
- **no**
  - **Unknown**

110 Pulmonary, moderate - Corrected diffusion capacity of carbon monoxide and/or FEV₁ 66-80% or dyspnea on slight activity at transplant
- **yes**
- **no**
  - **Unknown**

111 Pulmonary, severe - Corrected diffusion capacity of carbon monoxide and/or FEV₁ ≤ 65% or dyspnea at rest or requiring oxygen at transplant
- **yes**
- **no**
  - **Unknown**

112 Renal, moderate / severe - Serum creatinine > 2 mg/dL or > 177 μmol/L or on dialysis at transplant, OR prior renal transplantation
- **yes**
- **no**
  - **Unknown**

113 Rheumatologic - For example, any history of systemic lupus erythematosus, rheumatoid arthritis, polymyositis, mixed connective tissue disease, or polymyalgia rheumatica requiring treatment (do NOT include degenerative joint disease, osteoarthritis)
- **yes**
- **no**
  - **Unknown**

114 Solid tumor, prior - Treated at any time point in the patient’s past history, excluding non-melanoma skin cancer, leukemia, lymphoma or multiple myeloma
- **yes**
- **no**
  - **Unknown**

115 Breast cancer
- **yes**
- **no**

116 Year of diagnosis:

117 Central nervous system (CNS) malignancy (glioblastoma, astrocytoma)
- **yes**
- **no**

118 Year of diagnosis:

119 Gastrointestinal malignancy (colon, rectum, stomach, pancreas, intestine)
- **yes**
- **no**

120 Year of diagnosis:

121 Genitourinary malignancy (kidney, bladder, ovary, testicle, genitalia, uterus, cervix)
- **yes**
- **no**

122 Year of diagnosis:

123 Lung cancer
- **yes**
- **no**

124 Year of diagnosis:

125 Melanoma
- **yes**
- **no**

126 Year of diagnosis:

127 Oropharyngeal cancer (tongue, buccal mucosa)
- **yes**
- **no**

128 Year of diagnosis:

129 Sarcoma
- **yes**
- **no**

130 Year of diagnosis:

131 Thyroid cancer
- **yes**
- **no**

132 Year of diagnosis:

133 Other co-morbid condition
- **yes**
- **no**
  - **Unknown**

134 Specify other co-morbid condition:

135 Was there a history of malignancy (hematologic or non-melanoma skin cancer) other than the primary disease for which this HCT is being performed?
- **yes**
- **no**

Specify which malignancy(ies) occurred:

136 Acute myeloid leukemia (AML / ANLL)
- **yes**
- **no**

137 Year of diagnosis:
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<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
</table>
| 138      | Other leukemia, including ALL  
yes  no |
| 139 Year of diagnosis: |  |
| 140 Specify leukemia: |  |
| 141 Clonal cytogenetic abnormality without leukemia or MDS  
yes  no |
| 142 Year of diagnosis: |  |
| 143 Hodgkin disease  
yes  no |
| 144 Year of diagnosis: |  |
| 145 Lymphoma or lymphoproliferative disease  
yes  no |
| 146 Year of diagnosis: |  |
| 147 Was the tumor EBV positive?  
yes  no |
| 148 Other skin malignancy (basal cell, squamous)  
yes  no |
| 149 Year of diagnosis: |  |
| 150 Specify other skin malignancy: |  |
| 151 Myelodysplasia (MDS) / myeloproliferative (MPN) disorder  
yes  no |
| 152 Year of diagnosis: |  |
| 153 Other prior malignancy  
yes  no |
| 154 Year of diagnosis: |  |
| 155 Specify other prior malignancy: |  |

Pre-HCT Preparative Regimen (Conditioning)  
Questions: 156 - 316

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
</table>
| 156 Height at initiation of pre-HCT preparative regimen:  
inches  centimeters |
| 157 Actual weight at initiation of pre-HCT preparative regimen:  
pounds  kilograms |
| 158 Was a pre-HCT preparative regimen prescribed?  
yes  no |
| 159 Classify the recipient’s prescribed preparative regimen (Allogeneic HCTs only)  
- Myeloablative  
- Non-myeloablative (NST)  
- Reduced intensity (RIC) |
| 160 Date pre-HCT preparative regimen began:  
(irradiation or drugs) - - - - - -
(Use earliest date from question 164 radiation, or 169 - 316 chemotherapy) |
| 161 Was irradiation planned as part of the pre-HCT preparative regimen?  
yes  no |
| 162 What was the prescribed radiation field?  
- Total body  
- Total body by intensity-modulated radiation therapy (IMRT)  
- Total lymphoid or nodal regions  
- Thoracoabdominal region |
| 163 Total prescribed dose:  
(dose per fraction x total number of fractions)  
Gy  cGy |
| 164 Date started:  
- - - - - - |
| 165 Was the radiation fractionated?  
yes  no |
| 166 Prescribed dose per fraction:  
Gy  cGy |
| 167 Number of days:  
(include “rest” days) |
| 168 Total number of fractions: |  |
Indicate the total prescribed cumulative dose for the preparative regimen:

169 ALG, ALS, ATG, ATS
  • yes • no

170 Total prescribed dose: ________________________ mg/kg

171 Date started: ____________ - ____________

172 Specify source
  • ATGAM (horse)
  • ATG - Fresenius (rabbit)
  • Thymoglobulin (rabbit)
  • Other

173 Specifying other source: ________________________

174 Anthracycline
  • yes • no

175 Daunorubicin
  • yes • no

176 Total prescribed dose: ________________________ mg/m² mg/kg

177 Date started: ____________ - ____________

178 Doxorubicin (Adriamycin)
  • yes • no

179 Total prescribed dose: ________________________ mg/m² mg/kg

180 Date started: ____________ - ____________

181 Idarubicin
  • yes • no

182 Total prescribed dose: ________________________ mg/m² mg/kg

183 Date started: ____________ - ____________

184 Rubidazole
  • yes • no

185 Total prescribed dose: ________________________ mg/m² mg/kg

186 Date started: ____________ - ____________

187 Other anthracycline
  • yes • no

188 Total prescribed dose: ________________________ mg/m² mg/kg

189 Date started: ____________ - ____________

190 Specify other anthracycline: ________________________

191 Bleomycin (BLM, Blenoxane)
  • yes • no

192 Total prescribed dose: ________________________ mg/m² mg/kg

193 Date started: ____________ - ____________

194 Busulfan (Myleran)
  • yes • no

195 Total prescribed dose: ________________________ mg/m² mg/kg

196 Date started: ____________ - ____________

197 Specify administration
  • Oral • IV • Both

198 Carboplatin
  • yes • no

199 Total prescribed dose: ________________________ mg/m² mg/kg

200 Date started: ____________ - ____________
201. Were pharmacokinetics performed to determine preparative regimen drug dosing?
   - yes
   - no

202. Specify the target AUC: __________________________ mg/mL/minute

203. Cisplatin (Platinol, CDDP)
   - yes
   - no

204. Total prescribed dose: __________________________ mg/m² mg/kg

205. Date started: __________

206. Cladribine (2-CdA, Leustatin)
   - yes
   - no

207. Total prescribed dose: __________________________ mg/m² mg/kg

208. Date started: __________

209. Corticosteroids (excluding anti-nausea medication)
   - yes
   - no

210. Methylprednisolone (Solu-Medrol)
   - yes
   - no

211. Total prescribed dose: __________________________ mg/m² mg/kg

212. Date started: __________

213. Prednisone
   - yes
   - no

214. Total prescribed dose: __________________________ mg/m² mg/kg

215. Date started: __________

216. Dexamethasone
   - yes
   - no

217. Total prescribed dose: __________________________ mg/m² mg/kg

218. Date started: __________

219. Other corticosteroid
   - yes
   - no

220. Total prescribed dose: __________________________ mg/m² mg/kg

221. Date started: __________

222. Specify other corticosteroid:

223. Cyclophosphamide (Cytoxan)
   - yes
   - no

224. Total prescribed dose: __________________________ mg/m² mg/kg

225. Date started: __________

226. Cytarabine (Ara-C)
   - yes
   - no

227. Total prescribed dose: __________________________ mg/m² mg/kg

228. Date started: __________

229. Etoposide (VP-16, VePesid)
   - yes
   - no

230. Total prescribed dose: __________________________ mg/m² mg/kg

231. Date started: __________

232. Fludarabine
   - yes
   - no

233. Total prescribed dose: __________________________ mg/m² mg/kg

234. Date started: __________

235. Ilostillamide
   - yes
   - no

236. Total prescribed dose: __________________________ mg/m² mg/kg

237. Date started: __________
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238 Intrathecal therapy (chemotherapy)
   ☐ yes ☐ no

239 Intrathecal cytarabine (IT Ara-C)
   ☐ yes ☐ no

240 Total prescribed dose: ____________________________ mg/m\(^2\) mg/kg

241 Date started: ____ ____ ___________

242 Intrathecal methotrexate (IT MTX)
   ☐ yes ☐ no

243 Total prescribed dose: ____________________________ mg/m\(^2\) mg/kg

244 Date started: ____ ____ ___________

245 Intrathecal thiopeta
   ☐ yes ☐ no

246 Total prescribed dose: ____________________________ mg/m\(^2\) mg/kg

247 Date started: ____ ____ ___________

248 Other intrathecal drug
   ☐ yes ☐ no

249 Total prescribed dose: ____________________________ mg/m\(^2\) mg/kg

250 Date started: ____ ____ ___________

251 Specify other intrathecal drug: ____________________________

252 Melphalan (L-Pam)
   ☐ yes ☐ no

253 Total prescribed dose: ____________________________ mg/m\(^2\) mg/kg

254 Date started: ____ ____ ___________

255 Specify administration
   ☐ Oral ☐ IV ☐ Both

256 Mitoxantrone (Novantrone)
   ☐ yes ☐ no

257 Total prescribed dose: ____________________________ mg/m\(^2\) mg/kg

258 Date started: ____ ____ ___________

259 Monoclonal antibody
   ☐ yes ☐ no

260 Radio labeled mAb
   ☐ yes ☐ no

261 Total prescribed dose of radioactive component: ____________________________ mCi MBq

262 Date started: ____ ____ ___________

Specify radio labeled mAb:

263 Tositumomab (Bexxar)
   ☐ yes ☐ no

264 Ibritumomab tiuxetan (Zevalin)
   ☐ yes ☐ no

265 Other radio labeled mAb
   ☐ yes ☐ no

266 Specify other radio labeled mAb: ____________________________

267 Alemtuzumab (Campath)
   ☐ yes ☐ no

268 Total prescribed dose: ____________________________ mg/m\(^2\) mg/kg

269 Date started: ____ ____ ___________

270 Rituximab (Rituxan, anti CD20)
   ☐ yes ☐ no

271 Total prescribed dose: ____________________________ mg/m\(^2\) mg/kg

272 Date started: ____ ____ ___________
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<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>273 Gemtuzumab (Mylotarg, anti CD33)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>274 Total prescribed dose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>275 Date started:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>276 Other mAb</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>277 Total prescribed dose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>278 Date started:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>279 Specify other mAb:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>280 Nitrosourea</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>281 Carmustine (BCNU)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>282 Total prescribed dose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>283 Date started:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>284 CCNU (Lomustine)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>285 Total prescribed dose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>286 Date started:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>287 Other nitrosourea</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>288 Total prescribed dose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>289 Date started:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>290 Specify other nitrosourea:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>291 Pacitaxel (Taxol, Xytox)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>292 Total prescribed dose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>293 Date started:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>294 Teniposide (VM26)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>295 Total prescribed dose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>296 Date started:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>297 Thiopeta</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>298 Total prescribed dose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>299 Date started:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>300 Treosulfan</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>301 Total prescribed dose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>302 Date started:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>303 Tyrosine kinase inhibitors</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>304 Dasatinib (Sprycel)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>305 Total prescribed dose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>306 Date started:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>307 Imatinib mesylate (STI571, Gleevec)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>308 Total prescribed dose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>309 Date started:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>310 Nilotinib</td>
<td>☐ yes ☐ no</td>
</tr>
<tr>
<td>311 Total prescribed dose:</td>
<td>mg/m² mg/kg</td>
</tr>
<tr>
<td>312 Date started:</td>
<td></td>
</tr>
<tr>
<td>313 Other drug</td>
<td>☐ yes ☐ no</td>
</tr>
<tr>
<td>314 Total prescribed dose:</td>
<td>mg/m² mg/kg</td>
</tr>
<tr>
<td>315 Date started:</td>
<td></td>
</tr>
<tr>
<td>316 Specify other drug:</td>
<td></td>
</tr>
</tbody>
</table>

**GVHD Prophylaxis**

This section is to be completed for allogeneic HCTs only; autologous HCTs continue with question 344.

317 Was GVHD prophylaxis planned / given?

☐ yes ☐ no

Specify:

318 ALG, ALS, ATG, ATS

☐ yes ☐ no

319 Total dose: mg/kg

320 Specify source

☐ ATGAM (horse)

☐ ATG - Fresenius (rabbit)

☐ Thymoglobulin (rabbit)

☐ Other

321 Specify other source:

322 Corticosteroids (systemic)

☐ yes ☐ no

323 Cyclosporine (CSA, Neoral, Sandimmune)

☐ yes ☐ no

324 Cyclophosphamide (Cytoxan)

☐ yes ☐ no

325 Extra-corporeal photopheresis (ECP)

☐ yes ☐ no

326 FK 506 (Tacrolimus, Prograf)

☐ yes ☐ no

327 In vivo monoclonal antibody

☐ yes ☐ no

Specify in vivo monoclonal antibody:

328 Alemtuzumab (Campath)

☐ yes ☐ no

329 Anti CD 25 (Zenapax, Daclizumab, AntiTAC)

☐ yes ☐ no

330 Specify:

331 Etanercept (Enbrel)

☐ yes ☐ no

332 Infliximab (Remicade)

☐ yes ☐ no

333 Other in vivo monoclonal antibody

☐ yes ☐ no

334 Specify antibody:

335 In vivo immunotoxin

☐ yes ☐ no
**Form 2400 R5.0: Pre-Transplant Essential Data**

**Center:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>336 Specify immunotoxin:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>337 Methotrexate (MTX) (Amethopterin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>338 Mycophenolate mofetil (MMF) (CellCept)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>339 Sirolimus (Rapamycin, Rapamune)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>340 Blinded randomized trial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>341 Specify trial agent:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>342 Other agent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>343 Specify other agent:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other Toxicity Modifying Regimen**

**Questions: 344 - 344**

**Optional for non-U.S. Centers**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>344 Was KGF (palifermin, Kepivance) started or is there a plan to use it?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post-HCT Disease Therapy Planned as of Day 0**

**Questions: 345 - 357**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>345 Is this HCT part of a planned multiple (sequential) graft / HCT protocol?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>346 Is additional post-HCT therapy planned?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Questions 347 – 357 are optional for non-U.S. centers**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>347 Bortezomib (Velcade)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>348 Cellular therapy (e.g. DCI, DLI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>349 Dexamethasone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>350 Intrathecal therapy (chemotherapy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>351 Tyrosine kinase inhibitor (e.g. imatinib mesylate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>352 Lenalidomide (Revlimid)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>353 Local radiotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>354 Rituiximab (Rituaxan, MabThera)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>355 Thalidomide (Thalamid)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>356 Other therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Specify other therapy:**

First Name: ___________________________
Last Name: ___________________________
E-mail address: _______________________

Date: ___________________________