Form 2400 R7.0: Pre-Transplant Essential Data

Center: CRID:

**Key Fields**

- OMB No: 0915-0310
- Expiration Date: 10/31/2022
- Public Burden Statement: The purpose of the data collection is to fulfill the legislative mandate to establish and maintain a standardized database of allogeneic marrow and cord blood transplants performed in the United States or using a donor from the United States. The data collected also meets the C.W. Bill Young Cell Transplantation Program requirements to provide relevant scientific information not containing individually identifiable information available to the public in the form of summaries and data sets. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0310 and it is valid until 10/31/2022. This information collection is voluntary under The Stem Cell Therapeutic and Research Act of 2005, Public Law (Pub. L.) 109-129, as amended by the Stem Cell Therapeutic and Research Reauthorization Act of 2010, Public Law 111-264 (the Act) and the Stem Cell Therapeutic and Research Reauthorization Act of 2015, Public Law 114-104. Public reporting burden for this collection of information is estimated to average 0.68 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hsa.gov.

**Recipient Information**

<table>
<thead>
<tr>
<th>Questions: 1 - 25</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recipient Information</strong></td>
</tr>
</tbody>
</table>

1. Date of birth: __ __ __ ‘——’ __ __
2. Sex
   - male
   - female
3. Ethnicity
   - Hispanic or Latino
   - Not Hispanic or Latino
   - Not applicable (not a resident of the USA)
   - Unknown
4. Race (check all that apply)
   - White
   - Black or African American
   - Asian
   - American Indian or Alaska Native
   - Native Hawaiian or Other Pacific Islander
   - Not reported
   - Unknown
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5 Race detail (check all that apply)
- Eastern European
- Mediterranean
- Middle Eastern
- North Coast of Africa
- North American
- Northern European
- Western European
- White Caribbean
- White South or Central American
- Other White
- African
- African American
- Black Caribbean
- Black South or Central American
- Other Black
- Alaskan Native or Aleut
- North American Indian
- American Indian, South or Central America
- Caribbean Indian
- South Asian
- Filipino (Filipino)
- Japanese
- Korean
- Chinese
- Vietnamese
- Other Southeast Asian
- Guamanian
- Hawaiian
- Samoan
- Other Pacific Islander
- Unknown

6 Country of primary residence

7 State of residence of recipient (for residents of Brazil)

8 Province or territory of residence of recipient (for residents of Canada)

9 State of residence of recipient (for residents of USA)

10 NMDP Recipient ID (RID):

11 Zip or postal code for place of recipient’s residence: (USA recipients only) (last 4 digits optional)

12 Specify blood type (of recipient) (For allogeneic HCTs only)
- A
- B
- AB
- O

13 Specify Rh factor (of recipient) (For allogeneic HCTs only)
- Positive
- Negative

14 Has the recipient signed an IRB / ethics committee (or similar body) approved consent form for submitting research data to the NMDP / CIBMTR?
- Yes (recipient consented)
- No (recipient declined)
- Not approached

15 Did the recipient give permission to be directly contacted by CIBMTR for future research?
- Yes (recipient provided permission)
- No (recipient declined)
**Form 2400 R7.0: Pre-Transplant Essential Data**

**Center:**

**CRID:**

### Clinical Trials (1)

**Questions: 22 - 25**

22 **Study Sponsor**

- Specify other sponsor: ____________________________

23 **Study ID Number**

- ____________________________

24 **Subject ID:**

- ____________________________

### Hematopoietic Cellular Transplant (HCT) and Cellular Therapy

**Questions: 26 - 45**

26 **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

27 **Specify subsequent HCT planned**

- Autologous
- Allogeneic

28 **Has the recipient ever had a prior HCT?**

- Yes
- No

29 **Specify the number of prior HCTs:**

- ____________________________

30 **Were all prior HCTs reported to the CIBMTR?**

- Yes
- No
- Unknown

### Prior HCTs (1)

**Questions: 31 - 34**

31 **Date of the prior HCT:**

- ____________________________

32 **Was the prior HCT performed at a different institution?**

- Yes
- No

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

33 **Name:**

- ____________________________

34 **City:**

- ____________________________

35 **State:**

- ____________________________

36 **Country:**

- ____________________________

37 **What was the HPC source for the prior HCT? (check all that apply)**

- Autologous
- Allogeneic, unrelated
- Allogeneic, related
Form 2400 R7.0: Pre-Transplant Essential Data

Center: CRID:

35 Reason for current HCT
- Graft failure / insufficient hematopoietic recovery
- Persistent primary disease
- Recurrent primary disease
- Planned subsequent HCT, per protocol
- New malignancy (including PTLD and EBV lymphoma)
- Insufficient chimerism
- Other

36 Date of graft failure / rejection: __ __ __ __ ‘ __ ’ __ __
37 Date of relapse: __ __ __ __ ‘ __ ’ __ __
38 Date of secondary malignancy: __ __ __ __ ‘ __ ’ __ __
39 Specify other reason:

40 Has the recipient ever had a prior cellular therapy? (do not include DLIs)
- Yes
- No
- Unknown

41 Were all prior cellular therapies reported to the CIBMTR?
- Yes
- No
- Unknown

Prior Cellular Therapies (1) Questions: 42 - 45

42 Date of the prior cellular therapy: __ __ __ __ ‘ __ ’ __ __
43 Was the cellular therapy performed at a different institution?
- Yes
- No

44 Name: ________________________________
City: ________________________________
State: ________________________________
Country: ________________________________

45 Specify the source(s) for the prior cellular therapy (check all that apply)
- Autologous
- Allogeneic, unrelated
- Allogeneic, related

Donor Information Questions: 46 - 83

46 Multiple donors?
- yes
- no

47 Specify number of donors: ________________________________

Donor Information for this HCT (1) Questions: 48 - 83

48 Specify donor
- Autologous
- Allogeneic, related
- Allogeneic, unrelated

49 Specify product type (check all that apply)
- Bone marrow
- PBSC
- Single cord blood unit
- Other product

50 Specify other product:

51 Is the product genetically modified? If autologous, go to question 80. If allogeneic related, go to question 52. If allogeneic unrelated, go to question 56.
- Yes
- No
Form 2400 R7.0: Pre-Transplant Essential Data

52 Specify the related donor type
- Syngeneic (monozygotic twin)
- HLA-identical sibling (may include non-monozygotic twin)
- HLA-matched other relative (does NOT include a haplo-identical donor)
- HLA-mismatched relative

53 Specify the biological relationship of the donor to the recipient
- Mother
- Father
- Child
- Sibling
- Fraternal twin
- Maternal aunt
- Maternal uncle
- Maternal cousin
- Paternal aunt
- Paternal uncle
- Paternal cousin
- Grandparent
- Grandchild
- Other biological relative

54 Specify other biological relative:

55 Degree of mismatch (related donors only)
- HLA-mismatched 1 allele
- HLA-mismatched ≥ 2 alleles (does include haplo-identical donor)

56 Specify unrelated donor type
- HLA matched unrelated
- HLA mismatched unrelated

57 Did NMDP / Be the Match facilitate the procurement, collection, or transportation of the product?
- Yes
- No

58 Was this donor used for any prior HCTs? (for this recipient)
- Yes
- No

59 NMDP cord blood unit ID:

60 Prior Solid Organ Transplant (check all that apply)
- Heart
- Kidney
- Liver
- Lung
- Kidney/pancreas
- Liver/kidney
- Lung/kidney
- Heart/kidney
- Heart/lung
- Heart/kidney/lung

61 Prior Exposure: Potential Study Eligibility
- Yes
- No
- Unknown

62 Non-NMDP unrelated donor ID: (not applicable for related donors) (check one)

63 Global Registration Identifier for Donors (GRID)

64 Is the CBU ID also the ISBT DIN number?
- Yes
- No
- Unknown

65 Specify the ISBT DIN number:

66 Registry or UCB Bank ID

67 Specify other Registry or UCB Bank:

68 Date of birth (donor / infant)
- Known
- Unknown

69 Date of birth: (donor / infant) __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

70 Age (donor / infant)
- Known
- Unknown

71 Age: (donor / infant) __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ ____
Form 2400 R7.0: Pre-Transplant Essential Data

**Key Fields**

**Sequence Number:**

**Date Received:**

**CIBMTR Recipient ID:**

**Initials:**

**CIBMTR Center Number:**

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**ERROR CORRECTION FORM**

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<thead>
<tr>
<th>Sequence Number:</th>
<th>CIBMTR Recipient ID:</th>
<th>Initials:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Today’s Date:</th>
<th>Infusion Date:</th>
<th>CIBMTR Center Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month Day Year</td>
<td>Month Day Year</td>
<td></td>
</tr>
</tbody>
</table>

---

**Central: CRID:**

**Form 2400 R7.0: Pre-Transplant Essential Data**

### 74 Specify Rh factor (donor) (non-NMDP allogeneic donors only)

- Positive
- Negative

### 75 Donor CMV-antibodies (IgG or Total) (Allogeneic HCTs only)

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

### 76 Has the donor signed an IRB / ethics committee (or similar body) approved consent form to donate research blood samples to the NMDP / CIBMTR? (Related donors only)

- Yes (donor consented)
- No (donor declined)
- Not approached
- Not applicable (center not participating)

### 77 Date form was signed: __ __ __ __ __ __ __ __ __ __ __ __ __ __

### 78 Did the donor submit a research sample to the NMDP/CIBMTR repository? (Related donors only)

- Yes
- No

### 79 Research sample donor ID:

---

### Questions 82 - 83 are for autologous HCT recipients only. If other than autologous skip to question 84.

### 82 What agents were used to mobilize the autologous recipient for this HCT? (check all that apply)

- G-CSF (filgrastim, Neupogen)
- Pegylated G-CSF (pegfilgrastim, Neulasta)
- Plerixafor (Mozobil)
- Combined with chemotherapy
- Anti-CD20 (rituximab, Rituaxan)
- Other agent

### 83 Specify other agent:

---

### Clinical Status of Recipient Prior to the Preparative Regimen (Conditioning)

**Questions: 84 - 87**

### 84 What scale was used to determine the recipient’s functional status?

- Karnofsky (recipient age ≥ 16 years)
- Lansky (recipient age ≥ 1 year and < 16 years)

**Performance score prior to the preparative regimen:**

### 85 Karnofsky Scale (recipient age ≥ 16 years)

### 86 Lansky Scale (recipient age ≥ 1 year and < 16 years)

### 87 Recipient CMV-antibodies (IgG or Total)

- Reactive
- Non-reactive
- Indeterminate
- Not done

---

### Comorbid Conditions

**Questions: 88 - 116**

### 88 Has the patient been infected with COVID-19 (SARS-CoV-2) based on a positive test result at any time prior to the start of the preparative regimen / infusion?

- Yes
- No

### 89 Did the patient require hospitalization for management of COVID-19 (SARS-CoV-2) infection?

- Yes
- No

### 90 Was mechanical ventilation given for COVID-19 (SARS-CoV-2) infection?

- Yes
- No

### 91 Is there a history of mechanical ventilation? (excluding COVID-19 (SARS-CoV-2))

- Yes
- No

---

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Center: CRID: 

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>92 Is there a history of invasive fungal infection?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>93 Glomerular filtration rate (GFR) before start of preparative regimen (pediatric only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>94 Glomerular filtration rate (GFR): Unknown</td>
<td></td>
<td></td>
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<tr>
<td>95 Does the recipient have known complex congenital heart disease? (corrected or uncorrected) (excluding simple ASD, VSD, or PDA repair) (pediatric only)</td>
<td></td>
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<tr>
<td>96 Were there any co-existing diseases or organ impairment present according to the HCT comorbidity index (HCT-CI)? Source: Soror, M. L. (2013). How I assess comorbidities before hematopoietic cell transplantation. Blood, 121(15), 2864-2863.</td>
<td></td>
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<tr>
<td>97 Specify co-existing diseases or organ impairment (check all that apply)</td>
<td></td>
<td></td>
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<tr>
<td>Arthritia</td>
<td></td>
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<tr>
<td>Cardiac</td>
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<td></td>
<td></td>
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<tr>
<td>Cerebrovascular disease</td>
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<tr>
<td>Diabetes</td>
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<td></td>
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<tr>
<td>Heart valve disease</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hepatic, mild</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hepatic, moderate / severe</td>
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<td></td>
<td></td>
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<tr>
<td>Infection</td>
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<tr>
<td>Day 0</td>
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<tr>
<td>Inflammatory bowel disease</td>
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<tr>
<td>Obesity</td>
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<tr>
<td>Peptic ulcer</td>
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<tr>
<td>Psychiatric disturbance</td>
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<tr>
<td>Pulmonary, moderate</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Pulmonary, severe</td>
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<td></td>
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<tr>
<td>Renal, moderate / severe</td>
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<td></td>
</tr>
<tr>
<td>Rheumatologic</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Prior malignancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>98 Was the recipient on dialysis immediately prior to start of preparative regimen?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Center: CRID:

99 Specify prior malignancy (check all that apply)
- Breast cancer
- Central nervous system (CNS) malignancy (e.g., glioblastoma, astrocytoma)
- Gastrointestinal malignancy (e.g., colon, rectum, stomach, pancreas, intestine, esophageal)
- Genitourinary malignancy (e.g., kidney, bladder, ovary, testicle, genitalia, uterus, cervix, prostate)
- Leukemia (includes acute or chronic leukemia)
- Lung cancer
- Lymphoma (includes Hodgkin & non-Hodgkin lymphoma)
- MDS / MPN
- Melanoma
- Multiple myeloma / plasma cell disorder (PCD)
- Oropharyngeal cancer (e.g., tongue, buccal mucosa)
- Sarcoma
- Thyroid cancer
- Other skin malignancy (basal cell, squamous)
- Other hematologic malignancy
- Other solid tumor

100 Specify other skin malignancy: (prior)

101 Specify other hematologic malignancy: (prior)

102 Specify other solid tumor: (prior)

Use results within 4 weeks prior to the start of the preparative regimen, report results from the test performed closest to the start date. Biomarkers according to the augmented HCT comorbidity index Source: Biol Blood Marrow Transplant. 2015 Aug; 21(8): 1418-1424.

103 Serum ferritin (within 4 weeks prior to the start of the preparative regimen, use result closest to the start date)
- Known
- Unknown

104 ______________________________ ng/mL (µg/L)

105 Date sample collected: __ __ __ __ __ __ __ __ __ __

106 Upper limit of normal for your institution: ______________________________

107 Serum albumin (within 4 weeks prior to the start of the preparative regimen, use result closest to the start date)
- Known
- Unknown

108 ______________________________ g/dL  g/L

109 Date sample collected: __ __ __ __ __ __ __ __ __ __

110 Platelets (within 4 weeks prior to the start of the preparative regimen, use result closest to the start date)
- Known
- Unknown

111 ______________________________ x 10^9/L (x 10^3/mm^3)
- Known
- Unknown

112 Were platelets transfused ≤ 7 days before date of test?
- Yes
- No
- Unknown

113 Did the recipient have a prior solid organ transplant?
- Yes
- No

Prior Solid Organ Transplant (1) Questions: 114 - 116

114 Specify organ
- Bowel
- Heart
- Kidney(s)
- Liver
- Lung(s)
- Pancreas
- Other organ

115 Specify other organ: ______________________________

116 Year of prior solid organ transplant: ______________________________

Pre-HCT Preparative Regimen (Conditioning) Questions: 117 - 131

117 Height at initiation of pre-HCT preparative regimen: ______________________________ inches centimeters
### Form 2400 R7.0: Pre-Transplant Essential Data

**Center:** CRID:

### Key Fields
- Sequence Number: ____________
- Date Received: ____________
- CIBMTR Recipient ID: ____________
- Initials: ____________
- CIBMTR Center Number: ____________

### Preparative Regimen (1)

<table>
<thead>
<tr>
<th>Question</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>118</td>
<td>Actual weight at initiation of pre-HCT preparative regimen: ________________ pounds / kilograms</td>
</tr>
</tbody>
</table>
| 119      | Was a pre-HCT preparative regimen prescribed?  
|          | yes ☐ no ☐ |
| 120      | Classify the recipient’s prescribed preparative regimen (Allogeneic HCTs only)  
|          | ☐ Myeloablative  
|          | ☐ Non-myeloablative (NST)  
|          | ☐ Reduced intensity (RIC) |
| 121      | Was irradiation planned as part of the pre-HCT preparative regimen?  
|          | yes ☐ no ☐ |
| 122      | What was the prescribed radiation field?  
|          | ☐ Total body  
|          | ☐ Total body by intensity-modulated radiation therapy (IMRT)  
|          | ☐ Total lymphoid or nodal regions  
|          | ☐ Thoracoabdominal region |
| 123      | Total prescribed dose: (dose per fraction x total number of fractions) ________________ Gy / cGy |
| 124      | Date started: __ ______ - __ ______ - __ ______ |
| 125      | Was the radiation fractionated?  
|          | yes ☐ no ☐ |
| 126      | Total number of fractions: ________________ |

**Questions: 127 - 131**

### Indicate the total prescribed cumulative dose for the preparative regimen:

<table>
<thead>
<tr>
<th>Question</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>127</td>
<td>Drug: ________________</td>
</tr>
<tr>
<td>128</td>
<td>Specify other drug: ________________</td>
</tr>
<tr>
<td>129</td>
<td>Total prescribed dose: ________________ mg/m2 / mg/kg / AUC (mg x h/L) / AUC (µmol x min/L) / Css (µg/mL)</td>
</tr>
<tr>
<td>130</td>
<td>Date started: __ ______ - __ ______ - __ ______</td>
</tr>
</tbody>
</table>
| 131      | Specify administration:  
|          | Oral ☐ N ☐ Both |

### Additional Drugs Given In the Peri-Transplant Period

<table>
<thead>
<tr>
<th>Question</th>
<th>Details</th>
</tr>
</thead>
</table>
| 132      | ALG, ALS, ATG, ATS  
|          | yes ☐ no ☐ |
| 133      | Total prescribed dose: ________________ mg/kg |
| 134      | Specify source  
|          | ☐ ATGAM (horse)  
|          | ☐ ATG - Fresenius (rabbit)  
|          | ☐ Thymoglobulin (rabbit)  
|          | ☐ Other |
| 135      | Specify other source: ________________ |
| 136      | Alemtuzumab (Campath)  
|          | yes ☐ no ☐ |
| 137      | Total prescribed dose: ________________ mg/m2 / mg/kg / mg |
| 138      | Defibrotide  
|          | Yes ☐ No |
| 139      | KGF  
|          | Yes ☐ No |
| 140      | Ursodiol  
|          | Yes ☐ No |

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## Form 2400 R7.0: Pre-Transplant Essential Data

**GVHD Prophylaxis**

This section is to be completed for allogeneic HCTs only; autologous HCTs continue with question 144.

141 Was GVHD prophylaxis planned?

- [ ] Yes
- [ ] No

142 Specify drugs / intervention (check all that apply)

- Abatacept
- Anti CD 25 (Zanapax, Dadilizumab, AntiTAC)
- Blinded randomized trial
- Bortezomib
- CD34 enriched (CD34+ selection)
- Corticosteroids (systemic)
- Cyclophosphamide (Cytoxan)
- Cyclosporine (CSA, Neoral, Sandimmune)
- Extra-corporeal photopheresis (ECP)
- Ex-vivo T-cell depletion
- Filgotinib
- Maraviroc
- Methotrexate (MTX) (Amethopterin)
- Mycophenolate mofetil (MMF) (Cellcept)
- Ruxolitinib
- Sirolimus (Rapamycin, Rapamune)
- Tacrolimus (FK 506)
- Tocilizumab
- Other agent

143 Specify other agent: ____________________________ (do not report ATG, campath)

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

144 Is additional post-HCT therapy planned?

- [ ] Yes
- [ ] No
Questions 145 – 146 are optional for non-U.S. centers

145 Specify post-HCT therapy planned (check all that apply)

- Azacytidine (Vidaza)
- Blinatumomab
- Bortezomib (Velcade)
- Bosutinib
- Brentuximab
- Carfilzomib
- Cellular therapy (e.g. DCI, DLI)
- Crenolanib
- Daratumumab
- Dasatinib
- Decitabine
- Eliotuzumab
- Enasidenib
- Gilteritinib
- Ibrutinib
- Imanitib mesylate (Gleevec, Glivec)
- Intrathecal therapy (chemotherapy)
- Ivosidenib
- Ixazomib
- Lenalidomide (Revlimid)
- Lestaurtinib
- Local radiotherapy
- Midostaurin
- Nilotinib
- Obinutuzumab
- Pacritinib
- Ponatinib
- Quizartinib
- Rituximab (Rituxan, MabThera)
- Sorafenib
- Sunitinib
- Thalidomide (Thalomid)
- Other therapy
- Unknown

146 Specify other therapy: ________________________________

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Prior Exposure: Potential Study Eligibility

Questions: 147 - 147

Selecting any option(s) below may generate an additional supplemental form.

147 Specify if the recipient received any of the following (at any time prior to HCT / infusion) (check all that apply)

- Blinatumomab (BlinCyto)
- Gemtuzumab ozogamicin (Mylotarg)
- Inotuzumab ozogamicin (Besponsa)
- Adrienne Tepadin®
- Mogamulizumab (Poteligeo)
- None of the above