Form 2450 R4.0: Post-Transplant Essential Data

Center: CRID:

Key Fields

OMB No: 0915-0310
Expiration Date: 1/31/2020

Public Burden Statement: 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 project is 0915-0310. Public reporting burden for this collection of information is estimated to average 1.25 hours per response when collected at 100 days post-transplant, 1.15 hours per response when collected at 6 months and 12 months post-transplant, and 1.15 hours per response annually thereafter, 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 10-29, Rockville, Maryland, 20857.

Sequence Number:__________________________
Date Received: ____________________________
CIBMTR Center Number:_____________________
CIBMTR Research ID:________________________
Event date: ____________________________
HCT type: (check all that apply)
- Autologous
- Allogeneic, unrelated
- Allogeneic, related

Product type: (check all that apply)
- Bone marrow
- PBSC
- Single cord blood unit
- Multiple cord blood units
- Other product
  Specify: ____________________________

Visit
- 100 day
- 6 months
- 1 year
- 2 years
- > 2 years
  Specify: ____________________________

Survival Questions: 1 - 6

1 Date of actual contact with the recipient to determine medical status for this follow-up report: ____________________________
2 Specify the recipient's survival status at the date of last contact
  - Alive - Answers to subsequent questions should reflect clinical status since the date of last report.
  - Dead - Answers to subsequent questions should reflect clinical status between the date of last report and immediately prior to death.
3 Primary cause of death
  Specify: ____________________________
4 Specify: ____________________________

 Contributing COD (1) Questions: 5 - 6

5 Contributing cause of death
  Specify: ____________________________
6 Specify: ____________________________

Subsequent Transplant Questions: 7 - 13

7 Did the recipient receive a subsequent HCT since the date of last report?
  - yes
  - no

8 Date of subsequent HCT: ____________________________
Form 2450 R4.0: Post-Transplant Essential Data

Center: CRID:

9 What was the indication for subsequent HCT?
- Graft failure / insufficient hematopoietic recovery - Allogeneic HCTs Complete a Pre-TED Form 2400 for the subsequent HCT
- Persistent primary disease - Complete a Pre-TED Form 2400 for the subsequent HCT
- Recurrent primary disease - Complete a Pre-TED Form 2400 for the subsequent HCT
- Planned second HCT, per protocol - Complete a Pre-TED Form 2400 for the subsequent HCT
- New malignancy (including PTLD and EBV lymphoma) - Complete a Pre-TED Form 2400 for the subsequent HCT
- Insufficient chimerism - Complete a Pre-TED Form 2400 for the subsequent HCT
- Other - Complete a Pre-TED Form 2400 for the subsequent HCT

10 Specify other indication: __________________________________________

11 Source of HSCs
- Allogeneic, related
- Allogeneic, unrelated
- Autologous

12 Has the recipient received a cellular therapy since the date of last report? (e.g. DCI)
- Yes - Also complete Cellular Therapy Essential Data Pre-Infusion Form 4000
- No

13 Date of cellular therapy: _______ - _______ - _______ -

Initial ANC Recovery

Questions: 14 - 16

14 Was there evidence of initial hematopoietic recovery?
- Yes (ANC ≥ 500/mm³ achieved and sustained for 3 lab values)
- No (ANC ≥ 500/mm³ was not achieved)
- Not applicable (ANC never dropped below 500/mm³ at any time after the start of the preparative regimen)
- Previously reported - (Recipient's initial hematopoietic recovery was recorded on a previous report)

15 Date ANC ≥ 500/mm³ (first of 3 lab values): _______ - _______ - _______

16 Did late graft failure occur?
- Yes
- No

Initial Platelet Recovery

Questions: 17 - 18

(Optional for Non-U.S. Centers)

17 Was an initial platelet count ≥ 20 x 10^9/L achieved?
- Yes
- No
- Not applicable - Platelet count never dropped below 20 x 10^9/L
- Previously reported - ≥ 20 x 10^9/L was achieved and reported previously

18 Date platelets ≥ 20 x 10^9/L: _______ - _______ - _______

Graft vs. Host Disease

Questions: 19 - 38

This section is for allogeneic HCTs only. If this was an autologous HCT, continue to Liver Toxicity Prophylaxis.

19 Did acute GVHD develop since the date of last report?
- Yes
- No
- Unknown

20 Date of acute GVHD diagnosis: _______ - _______ - _______

21 Did acute GVHD persist since the date of last report?
- Yes
- No
- Unknown

22 Overall grade of acute GVHD at diagnosis
- I - Rash on ≤ 50% of skin, no liver or gut involvement
- II - Rash on > 50% of skin, bilirubin 2-3 mg/dL, or diarrhea 500-1000 mL/day or persistent nausea
- III - Bilirubin 3-15 mg/dL, or gut stage 2-4 diarrhea > 1000 mL/day or severe abdominal pain with or without ileus
- IV - Generalized erythroderma with bullous formation, or bilirubin > 15 mg/dL
- Not applicable (acute GVHD present but grade is not applicable)
List the stage for each organ at diagnosis of acute GVHD:

23 Skin
- Stage 0 - No rash, no rash attributable to acute GVHD
- Stage 1 - Maculopapular rash, < 25% of body surface
- Stage 2 - Maculopapular rash, 25-50% of body surface
- Stage 3 - Generalized erythroderma, >50% of body surface
- Stage 4 - Generalized erythroderma with bullae formation and/or desquamation

24 Lower intestinal tract (use mL/day for adult recipients and mL/kg/day for pediatric recipients)
- Stage 0 - No diarrhea, no diarrhea attributable to acute GVHD/diarrhea < 500 mL/day (adult), or < 10 mL/kg/day (pediatric)
- Stage 1 - Diarrhea 500-1000 mL/day (adult), or 10-19.9 mL/kg/day (pediatric)
- Stage 2 - Diarrhea 1001-1500 mL/day (adult), or 20-30 mL/kg/day (pediatric)
- Stage 3 - Diarrhea > 1500 mL/day (adult), or > 30 mL/kg/day (pediatric)
- Stage 4 - Severe abdominal pain, with or without ileus, and/or grossly bloody stool

25 Upper intestinal tract
- Stage 0 - No persistent nausea or vomiting
- Stage 1 - Persistent nausea or vomiting

26 Liver
- Stage 0 - No liver acute GVHD/bilirubin < 2.0 mg/dL (<34 μmol/L)
- Stage 1 - Bilirubin 2.0-3.0 mg/dL (34-52 μmol/L)
- Stage 2 - Bilirubin 3.1-6.0 mg/dL (53-103 μmol/L)
- Stage 3 - Bilirubin 6.1-15.0 mg/dL (104-256 μmol/L)
- Stage 4 - Bilirubin >15.0 mg/dL (>256 μmol/L)

27 Other site(s) involved with acute GVHD
- Yes  No

28 Specify other site(s):__________________________

Specify the maximum overall grade of acute GVHD since the date of last report

29 Maximum overall grade of acute GVHD
- I - Rash on ≤ 50% of skin, no liver or gut involvement
- II - Rash on > 50% of skin, bilirubin 2-3 mg/dL, or diarrhea 500-1000 mL/day or persistent nausea
- III - Bilirubin 3-15 mg/dL, or gut stage 2-4 diarrhea > 1000 mL/day or severe abdominal pain with or without ileus
- IV - Generalized erythroderma with bullous formation, or bilirubin > 15 mg/dL
- Not applicable (acute GVHD present but cannot be graded)

30 Date maximum overall grade of acute GVHD: ____________ - __________

31 Did chronic GVHD develop since the date of last report?
- Yes  No  Unknown

32 Date of chronic GVHD diagnosis: ____________ - ____________ Date estimated

33 Did chronic GVHD persist since the date of last report?
- Yes  No  Unknown

Specify the maximum grade of chronic GVHD since the date of last report:

34 Maximum grade of chronic GVHD (according to best clinical judgment)
- Mild  Moderate  Severe  Unknown

35 Specify if chronic GVHD was limited or extensive
- Limited - localized skin involvement and/or liver dysfunction
- Extensive - one or more of the following:
  - Generalized skin involvement; or
  - Liver histology showing chronic aggressive hepatitis, bridging necrosis or cirrhosis; or
  - Involvement of eye: Schirmer’s test with < 5mm wetting; or
  - Involvement of minor salivary glands or oral mucosa demonstrated on labial biopsy; or
  - Involvement of any other target organ

36 Date of maximum grade of chronic GVHD: ____________ - ____________
Form 2450 R4.0: Post-Transplant Essential Data

37 Is the recipient still taking systemic steroids? (Do not report steroids for adrenal insufficiency, ≤10 mg/day for adults, <0.1 mg/kg/day for children)
   - Yes
   - No
   - Not Applicable
   - Unknown

38 Is the recipient still taking (non-steroid) immunosuppressive agents (including PUVA) for GVHD?
   - Yes
   - No
   - Not Applicable
   - Unknown

Liver Toxicity Prophylaxis

Questions: 39 - 45

39 Was specific therapy used to prevent liver toxicity?
   - Yes
   - No

40 Defibrotide
   - Yes
   - No

41 N-acetylcysteine
   - Yes
   - No

42 Tissue plasminogen activator (TPA)
   - Yes
   - No

43 Ursodiol
   - Yes
   - No

44 Other therapy
   - Yes
   - No

45 Specify other therapy: __________________________

Veno-occlusive disease (VOD)/Sinusoidal obstruction syndrome (SOS)

Questions: 46 - 47

Specify if the recipient developed VOD/SOS since the date of last report:

46 Did veno-occlusive disease (VOD) / sinusoidal obstruction syndrome (SOS) develop since the date of last report?
   - Yes
   - No

47 Date of diagnosis: __________

New Malignancy, Lymphoproliferative or Myeloproliferative Disease / Disorder

Questions: 48 - 55

Report new malignancies that are different than the disease/disorder for which HCT was performed. Do not include relapse, progression or transformation of the same disease subtype.

48 Did a new malignancy, myelodysplastic, myeloproliferative, or lymphoproliferative disease / disorder occur that is different from the disease / disorder for which the HCT or cellular therapy was performed? (include clonal cytogenetic abnormalities, and post-transplant lymphoproliferative disorders)
   - Yes
   - No

New Malignancy (1)

Questions: 49 - 55

The submission of a pathology report or other supportive documentation for each reported new malignancy is strongly recommended.

49 Specify the new malignancy

50 Specify other new malignancy: __________________________

51 Is the tumor EBV positive?
   - Yes
   - No

52 Date of diagnosis: __________

53 Was documentation submitted to the CIBMTR? (e.g. pathology/autopsy report or other documentation)
   - Yes
   - No

54 Was the new malignancy donor / cell product derived?
   - Yes
   - No
   - Not done

55 Was documentation submitted to the CIBMTR? (e.g. cell origin evaluation (VNTR, cytogenetics, FISH))
   - Yes
   - No

Chimerism Studies (Cord Blood Units Only)

Questions: 56 - 74

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

Page 4 / 12
Form 2450 R4.0: Post-Transplant Essential Data

This section relates to chimerism studies from allogeneic HCTs using cord blood units only. If this was an autologous HCT, or an allogeneic HCT using a bone marrow or PBSC product, continue to disease assessment.

56 Were chimerism studies performed since the date of last report?
   ☐ yes  ☐ no

57 Was documentation submitted to the CIBMTR? (e.g. chimerism laboratory reports)
   ☐ Yes  ☐ No

58 Were chimerism studies assessed for more than one donor / multiple donors?
   ☐ Yes  ☐ No

Chimerism Studies (Cord Blood Units Only) (1)

Provide date(s), method(s) and other information for all chimerism studies performed since the date of last report.

59 AMDP donor ID: ____________________________

60 AMDP cord blood unit ID: ____________________________

61 Non-AMDP unrelated donor ID: ____________________________

62 Non-AMDP cord blood unit ID: ____________________________

63 Date of birth: (donor/infant) _______ - _______ - _______ OR Age: (donor/infant) _______ - _______ - _______ (months) (years)

64 Sex (donor/infant)
   ☐ male  ☐ female

65 Date sample collected: _______ - _______ - _______

66 Method
   ☐ Karyotyping for XX/XY
   ☐ Fluorescent in situ hybridization (FISH) for XX/XY
   ☐ Restriction fragment-length polymorphisms (RFLP)
   ☐ VNTR or STR, micro or mini satellite (Also include AFLP)
   ☐ Other

67 Specify: ____________________________

68 Cell source
   ☐ Bone marrow  ☐ Peripheral blood

69 Cell type
   ☐ Unsorted / whole
   ☐ Red blood cells
   ☐ Hematopoietic progenitor cells (CD34+ cells)
   ☐ Total mononuclear cells (lymphs & monos)
   ☐ T-cells (includes CD3+, CD4+, and/or CD8+)
   ☐ B-cells (includes CD19+ or CD20+)
   ☐ Granulocytes (includes CD33+ myeloid cells)
   ☐ NK cells (CD56+)
   ☐ Other

70 Specify: ____________________________

71 Total cells examined: ____________________________

72 Number of donor cells:

73 Were donor cells detected?
   ☐ Yes  ☐ No

74 Percent donor cells: ____________________________ %

Disease Assessment at the Time of Best Response to HCT

Questions: 75 - 97
Form 2450 R4.0: Post-Transplant Essential Data

Center: CRID:

75 Compared to the disease status prior to the preparative regimen, what was the best response to HCT since the date of the last report? (Include response to any therapy given for post-HCT maintenance or consolidation, but exclude any therapy given for relapsed, persistent, or progressive disease)
- Continued complete remission (CCR) (For recipients already in CR prior to the start of the preparative regimen.)
- Complete remission (CR)
- Not in complete remission
- Not evaluated

76 Specify disease status if not in complete remission
- Disease detected
- No disease detected but incomplete evaluation to establish CR

77 Was the date of best response previously reported?
- yes
- no

78 Date assessed:

Specify the method(s) used to assess the disease status at the time of best response:

79 Was the disease status assessed by molecular testing? (e.g. PCR)
- Yes
- No
- Not Applicable

80 Date assessed:

81 Was disease detected?
- yes
- no

82 Was the disease status assessed via flow cytometry?
- Yes
- No
- Not Applicable

83 Date assessed:

84 Was disease detected?
- yes
- no

85 Was the disease status assessed by cytogenetic testing? (karyotyping or FISH)
- Yes
- No
- Not Applicable

86 Was the disease status assessed via FISH?
- Yes
- No
- Not Applicable

87 Date assessed:

88 Was disease detected?
- yes
- no

89 Was the disease status assessed via karyotyping?
- Yes
- No
- Not Applicable

90 Date assessed:

91 Was disease detected?
- yes
- no

92 Was the disease status assessed by radiological assessment? (e.g. PET, MRI, CT)
- Yes
- No
- Not Applicable

93 Date assessed:

94 Was disease detected?
- yes
- no

95 Was the disease status assessed by clinical / hematologic assessment?
- yes
- no

96 Date assessed:

97 Was disease detected?
- yes
- no

Post-HCT Therapy

Report therapy given since the date of last report to prevent relapse or progressive disease. This may include maintenance and consolidation therapy. Do not report any therapy given for relapsed, persistent, or progressive disease.

98 Was therapy given since the date of the last report for reasons other than relapse, persistent, or progressive disease? (Include any maintenance and consolidation therapy)
- yes
- no
Form 2450 R4.0: Post-Transplant Essential Data

### 99 Systemic therapy
- **yes**  
- **no**

### 100 Monoclonal antibody (mAb)
- **Yes**  
- **No**

#### 101 Alemtuzumab (Campath)
- **yes**  
- **no**

#### 102 Bispecific mAb
- **Yes**  
- **No**

#### 103 Blinatumomab
- **Yes**  
- **No**

#### 104 Other bispecific mAb
- **Yes**  
- **No**

#### 105 Specify other bispecific mAb: __________________________

#### 106 Gemtuzumab (Mylotarg, anti-CD33)
- **yes**  
- **no**

#### 107 Rituximab (Rituxan, MabThera)
- **yes**  
- **no**

### 108 Other mAb
- **yes**  
- **no**

#### 109 Specify other mAb: __________________________

### 110 Tyrosine kinase inhibitors (TKI)
- **yes**  
- **no**

#### 111 Bosutinib
- **Yes**  
- **No**

#### 112 Dasatinib (Sprycel)
- **Yes**  
- **No**

#### 113 Imatinib mesylate (Gleevec)
- **yes**  
- **no**

#### 114 Nilotinib (AMN107, Tasigna)
- **yes**  
- **no**

#### 115 Other TKI
- **Yes**  
- **No**

#### 116 Specify other TKI: __________________________

### 117 FLT3 inhibitors
- **Yes**  
- **No**

#### 118 Gilotinib
- **Yes**  
- **No**

#### 119 Lestaurtinib
- **Yes**  
- **No**

#### 120 Midostaurin
- **Yes**  
- **No**

#### 121 Quizartinib
- **Yes**  
- **No**

#### 122 Sorafenib
- **yes**  
- **no**

#### 123 Sunitinib
- **Yes**  
- **No**

#### 124 Other FLT3 inhibitor
- **Yes**  
- **No**

#### 125 Specify other FLT3 inhibitor: __________________________
126 Hypomethylating agents
   ☐ Yes ☐ No

127 Azacitidine (Vidaza)
   ☐ yes ☐ no

128 Decitabine (Dacogen)
   ☐ yes ☐ no

129 Other hypomethylating agent
   ☐ Yes ☐ No

130 Specify other hypomethylating agent: __________________________

131 Proteasome inhibitors
   ☐ Yes ☐ No

132 Bortezomib (Velcade)
   ☐ yes ☐ no

133 Carfilzomib
   ☐ yes ☐ no

134Ixazomib
   ☐ Yes ☐ No

135 Other proteasome inhibitor
   ☐ Yes ☐ No

136 Specify other proteasome inhibitor: __________________________

137 Immune modulating agents
   ☐ Yes ☐ No

138 Lenalidomide (Revlimid)
   ☐ yes ☐ no

139 Pomalidomide
   ☐ yes ☐ no

140 Thalidomide (Thalomid)
   ☐ yes ☐ no

141 Other immune modulating agent
   ☐ Yes ☐ No

142 Specify other immune modulating agent: __________________________

143 PD1 inhibitor
   ☐ Yes ☐ No

144 Nivolumab
   ☐ Yes ☐ No

145 Pembrolizumab
   ☐ Yes ☐ No

146 Other PD1 inhibitor
   ☐ Yes ☐ No

147 Specify other PD1 inhibitor: __________________________

148 BTK inhibitors
   ☐ Yes ☐ No

149 Ibrutinib
   ☐ Yes ☐ No

150 Other BTK inhibitor
   ☐ Yes ☐ No

151 Specify other BTK inhibitor: __________________________

152 Chemotherapy
   ☐ yes ☐ no

153 Specify chemotherapy drugs: __________________________
**Form 2450 R4.0: Post-Transplant Essential Data**

Center: CRID:  

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>154 Other systemic therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>155 Specify other systemic therapy:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>156 Radiation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>157 Cellular therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>158 Blinded randomized trial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>159 Other therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>160 Specify other therapy:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Relapse or Progression Post-HCT**

Questions: 161 - 234

Report if the recipient has experienced a clinical/hematologic relapse or progression post HCT. If the relapse or progression was detected in a previous reporting period indicate that and continue on. If the first clinical/hematologic relapse occurred since the date of last report, indicate the date it was first detected in this reporting period.

161 Did the recipient experience a clinical/hematologic relapse or progression post-HCT?
   
   - Yes  
   - No

162 Was the date of clinical/hematologic relapse or progression previously reported?
   
   - Yes (only valid > day 100)  
   - No

163 Date first seen: _ _ _ _ _ _ _ _ _ _

**Intervention for relapsed disease, persistent disease, progressive disease, or decreased/loss of chimerism**

164 Was intervention given for relapsed, persistent or progressive disease, or decreased/loss of chimerism since the date of last report?
   
   - Yes  
   - No

165 Specify reason for which intervention was given
   
   - Persistent disease  
   - Relapsed / progressive disease  
   - Decrease / loss of chimerism

Specify the method(s) of detection for which intervention was given:

166 Clinical/hematologic
   
   - Yes  
   - No

167 Radiological (e.g. PET, MRI, CT)
   
   - Yes  
   - No

168 Cytogenetic
   
   - Yes  
   - No

169 Flow cytometry
   
   - Yes  
   - No

170 Disease specific molecular marker
   
   - Yes  
   - No

171 Chimerism testing
   
   - Yes  
   - No

172 Date intervention started: _ _ _ _ _ _ _ _

Specify intervention(s):

173 Systemic therapy
   
   - Yes  
   - No

174 Monoclonal antibody (mAb)
   
   - Yes  
   - No

175 Alemtuzumab (Campath)
   
   - Yes  
   - No

176 Bispecific mAb
   
   - Yes  
   - No

---

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

CIBMTR Form 2450 revision 4 last updated Tuesday, March 28, 2017 Copyright(c) 2012 National Marrow Donor Program
and The Medical College of Wisconsin, Inc. All rights reserved.
**Form 2450 R4.0: Post-Transplant Essential Data**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>177</td>
<td>Blinatumomab</td>
<td>( ) Yes ( ) No</td>
</tr>
<tr>
<td>178</td>
<td>Other bispecific mAb</td>
<td>( ) Yes ( ) No</td>
</tr>
<tr>
<td>179</td>
<td>Specify other bispecific mAb:</td>
<td></td>
</tr>
<tr>
<td>180</td>
<td>Gemtuzumab (Mylotarg, anti-CD33)</td>
<td>( ) yes ( ) no</td>
</tr>
<tr>
<td>181</td>
<td>Rituximab (Rituxan, MabThera)</td>
<td>( ) yes ( ) no</td>
</tr>
<tr>
<td>182</td>
<td>Other mAb</td>
<td>( ) yes ( ) no</td>
</tr>
<tr>
<td>183</td>
<td>Specify other mAb:</td>
<td></td>
</tr>
<tr>
<td>184</td>
<td>Tyrosine kinase inhibitors (TKI)</td>
<td>( ) yes ( ) no</td>
</tr>
<tr>
<td>185</td>
<td>Bosutinib</td>
<td>( ) Yes ( ) No</td>
</tr>
<tr>
<td>186</td>
<td>Dasatinib (Sprycel)</td>
<td>( ) yes ( ) no</td>
</tr>
<tr>
<td>187</td>
<td>Imatinib mesylate (Gleevec)</td>
<td>( ) yes ( ) no</td>
</tr>
<tr>
<td>188</td>
<td>Nilotinib (AMN107, Tasigna)</td>
<td>( ) yes ( ) no</td>
</tr>
<tr>
<td>189</td>
<td>Other TKI</td>
<td>( ) Yes ( ) No</td>
</tr>
<tr>
<td>190</td>
<td>Specify other TKI:</td>
<td></td>
</tr>
<tr>
<td>191</td>
<td>FLT3 inhibitors</td>
<td>( ) Yes ( ) No</td>
</tr>
<tr>
<td>192</td>
<td>Gil velitinib</td>
<td>( ) Yes ( ) No</td>
</tr>
<tr>
<td>193</td>
<td>Lestaurtinib</td>
<td>( ) Yes ( ) No</td>
</tr>
<tr>
<td>194</td>
<td>Midostaurin</td>
<td>( ) Yes ( ) No</td>
</tr>
<tr>
<td>195</td>
<td>Quizartinib</td>
<td>( ) Yes ( ) No</td>
</tr>
<tr>
<td>196</td>
<td>Sorafenib</td>
<td>( ) yes ( ) no</td>
</tr>
<tr>
<td>197</td>
<td>Sunitinib</td>
<td>( ) Yes ( ) No</td>
</tr>
<tr>
<td>198</td>
<td>Other FLT3 inhibitor</td>
<td>( ) Yes ( ) No</td>
</tr>
<tr>
<td>199</td>
<td>Specify other FLT3 inhibitor:</td>
<td></td>
</tr>
<tr>
<td>200</td>
<td>Hypomethylating agents</td>
<td>( ) Yes ( ) No</td>
</tr>
<tr>
<td>201</td>
<td>Azacitidine (Vidaza)</td>
<td>( ) yes ( ) no</td>
</tr>
<tr>
<td>202</td>
<td>Decitabine (Dacogen)</td>
<td>( ) yes ( ) no</td>
</tr>
<tr>
<td>203</td>
<td>Other hypomethylating agent</td>
<td>( ) Yes ( ) No</td>
</tr>
<tr>
<td>204</td>
<td>Specify other hypomethylating agent:</td>
<td></td>
</tr>
</tbody>
</table>
### Form 2450 R4.0: Post-Transplant Essential Data

**Center:**

**CRID:**

<table>
<thead>
<tr>
<th>205</th>
<th>Proteasome inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>206</td>
<td>Bortezomib (Velcade)</td>
</tr>
<tr>
<td>207</td>
<td>Carfilzomib</td>
</tr>
<tr>
<td>208</td>
<td>Ixazomib</td>
</tr>
<tr>
<td>209</td>
<td>Other proteasome inhibitor</td>
</tr>
</tbody>
</table>

**Specify other proteasome inhibitor:**

<table>
<thead>
<tr>
<th>210</th>
<th>Immune modulating agents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>211</td>
<td>Lenalidomide (Revlimid)</td>
</tr>
<tr>
<td>212</td>
<td>Pomalidomide</td>
</tr>
<tr>
<td>213</td>
<td>Thalidomide (Thalomid)</td>
</tr>
<tr>
<td>214</td>
<td>Other immune modulating agent</td>
</tr>
</tbody>
</table>

**Specify other immune modulating agent:**

<table>
<thead>
<tr>
<th>216</th>
<th>PD1 inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>217</td>
<td>Nivolumab</td>
</tr>
<tr>
<td>218</td>
<td>Pembrolizumab</td>
</tr>
<tr>
<td>219</td>
<td>Other PD1 inhibitor</td>
</tr>
</tbody>
</table>

**Specify other PD1 inhibitor:**

<table>
<thead>
<tr>
<th>221</th>
<th>BTK inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>222</td>
<td>Ibrutinib</td>
</tr>
<tr>
<td>223</td>
<td>Other BTK inhibitor</td>
</tr>
</tbody>
</table>

**Specify other BTK inhibitor:**

<table>
<thead>
<tr>
<th>225</th>
<th>Chemotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Specify chemotherapy drugs:**

<table>
<thead>
<tr>
<th>227</th>
<th>Other systemic therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Specify other systemic therapy:**

<table>
<thead>
<tr>
<th>229</th>
<th>Radiation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>230</td>
<td>Cellular therapy</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>231</td>
<td>Blinded randomized trial</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Form 2450 R4.0: Post-Transplant Essential Data

**Center:**

**CRID:**

#### 233 Other therapy
- **Yes**
- **No**

#### 234 Specify other therapy: ____________________________

#### Current Disease Status

<table>
<thead>
<tr>
<th>Questions: 235 - 238</th>
</tr>
</thead>
</table>

**235 What is the current disease status?**
- **Complete remission (CR)**
- **Not in complete remission**
- **Not evaluated**

**236 Specify disease status if not in complete remission**
- **Disease detected**
- **No disease detected but incomplete evaluation to establish CR**

**237 Date of most recent disease assessment**
- **Known**
- **Unknown**

**238 Date of most recent disease assessment:** ____________

**First Name:** ____________________________

**Last Name:** ____________________________

**E-mail address:** ____________________________

**Date:** ____________

---

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

CIBMTR Form 2450 revision 4 last updated Tuesday, March 28, 2017 Copyright(c) 2012 National Marrow Donor Program and The Medical College of Wisconsin, Inc. All rights reserved.