1. Were corrections made to the 002-Core report form according to the data reported on this form?  
   1 ☐ yes  
   2 ☐ no

Post-Preparative Regimen

Has the recipient received the following hematopoietic lymphoid growth factors or cytokines after the start of the preparative regimen?

2. KGF (palifermin, Kepivance) [345, 2, 408, 409]
   1 ☐ yes  
   2 ☐ no

3. Date therapy started: [346]  
   Month ☐ Day ☐ Year ☐

4. Specify therapy given: [347]  
   1 ☐ prevention of acute GVHD  
   2 ☐ planned therapy to prevent mucositis

5. Velafermin [358, 359, 408, 409]
   1 ☐ yes  
   2 ☐ no

6. Date therapy started: [360]  
   Month ☐ Day ☐ Year ☐

7. Specify therapy given: [361]  
   1 ☐ prevention of acute GVHD  
   2 ☐ planned therapy to prevent mucositis

Specify if the recipient developed any of the following clinically significant organ impairments or disorders after the start of the preparative regimen through the date of last contact: [715–716, 722, 727–728]

8. Cataracts [722]
   1 ☐ yes  
   2 ☐ no

9. Date of diagnosis:  
   Month ☐ Day ☐ Year ☐
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Pancreatitis [727, 728]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Renal failure severe enough to warrant dialysis [715]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Did the recipient receive dialysis? [716]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Signed:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Person completing form

Please print name: ____________________________________________

Phone number: (_______) ______________________________________

Fax number: (_______) ________________________________________

E-mail address: ____________________________________________

Fax this form to your designated campus (Milwaukee 414-456-6165 or Minneapolis 612-627-5895).