

ERROR CORRECTION FORM

Sequence Number:
CIBMTR Recipient ID: Initials:
Today's Date: 2 0
Month Day Year
Infusion Date: 2 0
Month Day Year
CIBMTR Center Number:

Form 2541 R1.0: Inotuzumab Ozogamicin (Besponsa™) Supplemental Data Collection Form

Center: _____

CRID: _____

Key Fields

Sequence Number: _____

Date Received: ____-____-____

CIBMTR Center Number: _____

CIBMTR Research ID: _____

Event date: ____-____-____

Inotuzumab Ozogamicin (Besponsa™)

Questions: 1 - 14

1 Did the recipient receive more than one cycle of Inotuzumab ozogamicin? (Besponsa™) (1 cycle = 3 doses)

Yes No

2 Number of cycles: _____

Cycle(s) (1)

Questions: 3 - 14

Report the start / stop date of each cycle of Inotuzumab ozogamicin (Besponsa™)

3 Date of first dose for cycle

Known Unknown

4 Date of first dose for cycle: ____-____-____

5 Date of last dose for cycle

Known Unknown

6 Date of last dose for cycle: ____-____-____

7 Combined dose per cycle (e.g. if patient received 3 doses in cycle 1 at 0.8 mg in day 1, 0.5 in days 8 and 14 then total dose is 1.8 mg)

Known Unknown

8 Dose: _____ mg/m²

9 Were three doses given in this cycle?

Yes No

10 Best response to this cycle of therapy

Complete remission - All of the following response criteria without progression for at least four weeks: < 5% blasts in the bone marrow, no blasts with Auer rods, no extramedullary disease (e.g., central nervous system or soft tissue involvement), ANC of ≥ 1,000/μL, Platelets ≥ 100,000/μL. (CR)

Complete remission with incomplete hematologic recovery (CRi) - All CR criteria except for residual neutropenia (< 1000/μL) and/or thrombocytopenia (< 100,000/μL)

No complete remission

11 Was recipient MRD negative following this cycle of therapy?

Yes No Not done

12 MRD method of detection

Known Unknown

13 Minimal residual disease (MRD) testing method

Flow cytometry

Next generation sequencing (NGS)

Polymerase chain reaction (PCR)

14 MRD

Positive Negative

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.