Form 2557 R1.0: Myelofibrosis CMS Study Post-HCT Supplemental Form

Center: CRID:

Key Fields

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 ○ 1 year

Disease Assessment since the Date of Last Report

Questions: 1 - 25

1 Spleen size

○ Known
○ Unknown
○ Not applicable **(splenectomy)**

2 Specify the spleen size: _____ **centimeters below right costal margin**

Specify the laboratory values since the date of last report:

3 Was presence of somatic mutations tested?

○ Yes ○ No ○ Unknown

4 Date sample collected: __ __ __ __ - __ __- __ __

5 Specify sample source

○ Bone marrow ○ Peripheral blood

6 JAK 2

○ Positive ○ Negative ○ Not done

7 CALR1

○ Positive ○ Negative ○ Not done

8 CALR2

○ Positive ○ Negative ○ Not done

9 MPL

○ Positive ○ Negative ○ Not done

10 ASXL1

○ Positive ○ Negative ○ Not done

11 SRSF2

○ Positive ○ Negative ○ Not done

12 EZH2

○ Positive ○ Negative ○ Not done

13 IDH1

○ Positive ○ Negative ○ Not done

14 IDH2

○ Positive ○ Negative ○ Not done

15 LNK

○ Positive ○ Negative ○ Not done

16 CBL

○ Positive ○ Negative ○ Not done

17 TET2

○ Positive ○ Negative ○ Not done

18 IKZF1

Positive Negative Not done

19 DNMT3A

Positive Negative Not done

20 TP53

Positive Negative Not done

21 SF3B1

Positive Negative Not done

22 U2AF1

Positive Negative Not done

23 FLT3

Positive Negative Not done

Disease Assessment since the Date of Last Report (1) — Questions: 24 - 25

24 Other gene mutation

Positive Negative Not done

25 Specify other gene mutation: _____

First Name: _____ Last Name: _____

E-mail address: _____ Date: __ __ __ __ - __ __- __ __