ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day 20 Year | Infusion Date: Month Day 20 Year | CIBMTR Center Number:

Form 4000 R5.0: Cellular Therapy Essential Data Pre-Infusion Form

Center: CRID:

Key Fields

Sequence Number: _____

Date Received: __ __ __ __ - __ __- __ __

CIBMTR Center Number: _____

CIBMTR Research ID: _____

Event date: __ __ __ __ - __ __- __ __

Recipient Data

Questions: 1 - 13

This form must be completed for all recipients of non-HCT cellular products. For recipients of hematopoietic cell transplants, complete a form 2400 - Pre-Transplant Essential Data.

This form reflects baseline recipient data for one course of cellular therapy.

1 Ethnicity

- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Not applicable (not a resident of the USA)
- ○ Unknown

2 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

3 Has the recipient signed an IRB / Ethics Committee-approved consent form for submitting research data to the CIBMTR?

- ○ Yes (patient consented)
- ○ No (patient declined)
- ○ Not approached
- ○ Not applicable

4 Date form was signed: __ __ __ __ - __ __- __ __

5 Is the recipient participating in a cellular therapy clinical trial?

- ○ yes ○ no

Clinical Trials (1)

Questions: 6 - 11

6 Study sponsor

- ○ BMT CTN
- ○ RCI BMT
- ○ USIDNET
- ○ COG
- ○ Corporate / Industry
- ○ EudraCT
- ○ UMIN
- ○ Investigator initiated
- ○ Other

7 Specify corporate / industry sponsor name: _____

8 Specify EudraCT number: _____

9 Specify UMIN number: _____

10 Specify other sponsor: _____

11 Specify the ClinicalTrials.gov identification number: _____

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

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month / Day / 20 Year | Infusion Date: Month / Day / 20 Year | CIBMTR Center Number:

Form 4000 R5.0: Cellular Therapy Essential Data Pre-Infusion Form

Center: CRID:

12 Is the recipient receiving cellular therapy outside the context of a clinical trial?

○ Yes ○ No

13 Specify the reason for not being on a clinical trial (check all that apply)

- ☐ Institutional guidelines / standard treatment
- ☐ Hospital exemption
- ☐ Compassionate use

Cellular Therapy and HCT History — Questions: 14 - 28

14 Is this the first application of cellular therapy (non-HCT)?

- ○ Yes
- ○ No (recipient has previously been treated using cellular therapy)
- ○ Unknown

15 Were all prior cellular therapies (non-HCT) reported to the CIBMTR?

○ Yes ○ No ○ Unknown

16 Specify the number of prior cellular therapies: _____

Prior Cellular Therapies (1) — Questions: 17 - 22

17 Date of the prior cellular therapy: __ __ __ __ - __ __ - __ __ ☐ Date estimated

18 Was the cellular therapy performed at a different institution?

○ Yes ○ No

Specify the institution that performed the prior cellular therapy:

19 Name: _____

City: _____

State: _____

Country: _____

20 Specify the indication for the prior cellular therapy

- ○ Promote stem cell engraftment (e.g. co-infusion with HCT)
- ○ Suboptimal donor chimerism (post-HCT)
- ○ Immune reconstitution (post-HCT)
- ○ GVHD prophylaxis (with HCT)
- ○ GVHD treatment (post-HCT)
- ○ Prevent disease relapse (post-HCT)
- ○ Relapsed, persistent or progressive disease (post-HCT)
- ○ Infection treatment
- ○ Infection prophylaxis
- ○ B cell lymphoproliferative disorder (PTLD, EBV lymphoma)
- ○ Autoimmune disease
- ○ Cardiovascular disease
- ○ Musculoskeletal disorder
- ○ Neurologic disease
- ○ Ocular disease
- ○ Pulmonary disease
- ○ Solid tumor
- ○ Malignant hematologic disorder
- ○ Non-malignant disorder
- ○ Unknown
- ○ Other indication

21 Specify other indication: _____

Form 4000 R5.0: Cellular Therapy Essential Data Pre-Infusion Form

Center: CRID:

22 What was the cell source for the prior cellular therapy? (check all that apply)

- ☐ Autologous
- ☐ Allogeneic, unrelated
- ☐ Allogeneic, related

HCT History

23 Has the recipient ever had a prior HCT?

○ Yes ○ No ○ Unknown

24 Were all prior HCTs reported to the CIBMTR?

○ Yes ○ No ○ Unknown

Prior HCTs (1) — Questions: 25 - 28

25 Date of the prior HCT: __ __ __ __ - __ __- __ __

26 Was the HCT performed at a different institution?

○ Yes ○ No

Specify the institution that performed the prior HCT:

27 Name: _____

City: _____

State: _____

Country: _____

28 Specify the HSC source(s) for the prior HCT (check all that apply)

- ☐ Autologous
- ☐ Allogeneic, unrelated
- ☐ Allogeneic, related

Product Identification — Questions: 29 - 46

29 Specify the total number of products: (per protocol) (as part of this course of cellular therapy) _____

30 Is the product genetically modified?

○ Yes ○ No

Donor Information (1) — Questions: 31 - 43

31 Specify the cell source

- ○ Autologous
- ○ Allogeneic, unrelated
- ○ Allogeneic, related

32 Specify the related donor type

- ○ Syngeneic (monozygotic twin)
- ○ HLA-identical sibling (may include non-monozygotic twin)
- ○ HLA-matched other relative
- ○ HLA-mismatched relative

33 Was this donor used for any prior cellular therapies or HCT? **(for this recipient)**

○ Yes ○ No ○ Unknown

Form 4000 R5.0: Cellular Therapy Essential Data Pre-Infusion Form

Center: CRID:

34 What is the tissue source of the cellular product? (check all that apply)

- ☐ Bone marrow
- ☐ Cord blood unit
- ☐ Peripheral blood
- ☐ Adipose tissue
- ☐ Amniotic fluid
- ☐ Cardiac tissue
- ☐ Hepatic tissue
- ☐ Neuronal tissue
- ☐ Ophthalmic tissue
- ☐ Pancreatic tissue
- ☐ Placenta
- ☐ Tumor
- ☐ Umbilical cord
- ☐ Other tissue source
- ☐ Unknown

35 Specify other tissue source: _____

36 What is the cell type? (Check all that apply)

- ☐ Lymphocytes (unselected)
- ☐ CD4+ lymphocytes
- ☐ CD8+ lymphocytes
- ☐ Cytotoxic T lymphocytes (CTLs)
- ☐ Natural killer cells (NK cells)
- ☐ Dendritic cells / tumor cell hybridomas (tumor vaccines)
- ☐ Mesenchymal stromal stem cells (MSCs)
- ☐ Unspecified mononuclear cells
- ☐ Endothelial progenitor cells
- ☐ Human umbilical cord perivascular (HUCPV) cells
- ☐ Cardiac progenitor cells
- ☐ Islet cells
- ☐ Oligodendrocytes
- ☐ Other cell type

37 Specify other cell type: _____

38 Where was the cellular therapy product manufactured / processed?

- ○ Pharmaceutical / biotech company
- ○ Cell processing laboratory off site
- ○ Cell processing laboratory at the same center as the product is being infused
- ○ Other site

39 Specify other site: _____

40 Specify pharmaceutical / biotech company

- ○ Atara Biotherapeutics
- ○ Bellicum Pharmaceuticals
- ○ Bluebird Bio
- ○ Celgene
- ○ Juno Therapeutics
- ○ Kite Pharma
- ○ Mesoblast
- ○ Novartis
- ○ Other pharmaceutical company

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month / Day / 20 Year | Infusion Date: Month / Day / 20 Year | CIBMTR Center Number:

Form 4000 R5.0: Cellular Therapy Essential Data Pre-Infusion Form

Center: CRID:

Specify the institution / company where the cellular product was manufactured:

41 Name: _____

City: _____

State: _____

Country: _____

42 Name of product

- Tisagenlecleucel (Kymriah®)
- Axicabtagene Ciloleucel (Yescarta®)
- Other product

43 Specify other product: _____

Planned HCT

44 Is a subsequent HCT part of the overall treatment protocol?

- Yes
- No

45 Specify the HCT type

- Autologous
- Allogeneic

46 Specify the circumstances in which the subsequent HCT will be performed

- Regardless of response to cellular therapy
- Only if the patient responds to cellular therapy
- Only if the patient fails to respond or has an incomplete response

Indication for Cellular Therapy

Questions: 47 - 60

47 Is the cellular therapy being given for prevention?

- Yes
- No

48 Reason for prevention

- GVHD prophylaxis (with HCT)
- Prevent disease relapse (post-HCT)
- Infection prophylaxis

49 Indication for cellular therapy

- Suboptimal donor chimerism (Post-HCT)
- Immune reconstitution (Post-HCT)
- GVHD treatment (Post-HCT)
- Malignant hematologic disorder **- Also complete CIBMTR Form 2402**
- Non-malignant disorder **- Also complete CIBMTR Form 2402**
- Solid tumor **- Also complete CIBMTR Form 2402**
- Cardiovascular disease
- Musculoskeletal disease
- Neurologic disease
- Ocular disease
- Pulmonary disease
- Infection treatment
- Other indication

50 Date of diagnosis: __ __ __ __ - __ __ - __ __

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month / Day / 20 Year | Infusion Date: Month / Day / 20 Year | CIBMTR Center Number:

Form 4000 R5.0: Cellular Therapy Essential Data Pre-Infusion Form

Center: CRID:

Cardiovascular disease

51 Specify cardiovascular disease

- AMI, acute myocardial infarction (701)
- Chronic coronary artery disease (ischemic, cardiomyopathy) (702)
- Heart failure (non-ischemic etiology) (703)
- Other cardiovascular disease (709)
- Limb ischemia (710)
- Thromboangitis obliterans (711)
- Other peripheral vascular disease (719)

52 Specify other cardiovascular disease: _____

53 Specify other peripheral vascular disease: _____

Musculoskeletal

54 Specify musculoskeletal disorder

- Avascular necrosis of femoral head (721)
- Osteoarthritis (722)
- Osteogenesis imperfecta (723)
- Traumatic joint injury (724)
- Other musculoskeletal disorder (729)

55 Specify other musculoskeletal disorder: _____

Neurologic Disease

56 Specify neurologic disease

- Acute cerebral vascular ischemia (731)
- ALS, amiotrophic lateral sclerosis (732)
- Parkinson disease (733)
- Spinal cord injury (734)
- Cerebral palsy (753)
- Congenital hydrocephalus (754)
- Myasthenia gravis (601)
- Duchenne muscular dystrophy (735)
- Other neurologic disease (749)

57 Specify other neurologic disease: _____

Ocular

58 Specify ocular disease: _____

Pulmonary

59 Specify pulmonary disease: _____

Other

60 Specify other indication: _____

Infection

Questions: 61 - 67

Specify organism code(s):

61 _____

62 _____

63 _____

64 _____

65 _____

66 _____

67 Specify other organism: _____

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

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month / Day / 20 Year | Infusion Date: Month / Day / 20 Year | CIBMTR Center Number:

Form 4000 R5.0: Cellular Therapy Essential Data Pre-Infusion Form

Center: CRID:

Disease Assessment at Last Evaluation Prior to Cellular Therapy

Questions: 68 - 93

Specify the method(s) of disease detection below. For each method used, if the result was positive report the first date the disease was detected; if the result was negative report the last date the method was used prior to cellular therapy.

68 Was the disease assessed prior to the cellular therapy?
○ Yes ○ No

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

70 Date sample collected: __ __ __ __ - __ __- __ __

71 Was disease detected?
○ yes ○ no

72 Was the status considered a disease relapse or progression?
○ yes ○ no

73 Was the disease status assessed via flow cytometry? (immunophenotyping)
○ Yes ○ No ○ Not Applicable

74 Date sample collected: __ __ __ __ - __ __- __ __

75 Was disease detected?
○ yes ○ no

76 Was the status considered a disease relapse or progression?
○ yes ○ no

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

78 Was the disease status assessed via karyotyping?
○ Yes ○ No ○ Not Applicable

79 Date sample collected: __ __ __ __ - __ __- __ __

80 Was disease detected?
○ yes ○ no

81 Was the status considered a disease relapse or progression?
○ yes ○ no

82 Was the disease status assessed via FISH?
○ Yes ○ No ○ Not Applicable

83 Date sample collected: __ __ __ __ - __ __- __ __

84 Was disease detected?
○ yes ○ no

85 Was the status considered a disease relapse or progression?
○ yes ○ no

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

87 Date assessed: __ __ __ __ - __ __- __ __

88 Was disease detected?
○ yes ○ no

89 Was the disease status assessed by clinical / hematologic assessment?
○ yes ○ no

90 Date assessed: __ __ __ __ - __ __- __ __

91 Was disease detected?
○ yes ○ no

92 What was the recipient's disease status immediately prior to the cellular therapy?
○ Complete remission (CR)
○ Not in complete remission

93 Date assessed: __ __ __ __ - __ __- __ __

Systemic Therapy Prior to Cellular Therapy

Questions: 94 - 249

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day 20 Year | Infusion Date: Month Day 20 Year | CIBMTR Center Number:

Form 4000 R5.0: Cellular Therapy Essential Data Pre-Infusion Form

Center: CRID:

94 Was systemic therapy given immediately prior to cellular therapy as part of the cellular therapy protocol?
yes no

95 Date started: __ __ __ __ - __ __- __ __

96 Specify the reason for which the systemic therapy was given per protocol
- Lympho-depleting therapy
- Reduction of tumor burden
- Other reason

97 Specify other reason: _____

98 ALG, ALS, ATG, ATS
yes no

99 Total dose: _____ mg

100 Date started: __ __ __ __ - __ __- __ __

101 Specify source
- ATGAM (horse)
- ATG - Fresenius (rabbit)
- Thymoglobulin (rabbit)
- Other

102 Specify other source: _____

103 Anthracycline
Yes No

104 Daunorubicin (Cerubidine)
yes no

105 Total dose: _____ mg

106 Date started: __ __ __ __ - __ __- __ __

107 Doxorubicin (Adriamycin)
yes no

108 Total dose: _____ mg

109 Date started: __ __ __ __ - __ __- __ __

110 Idarubicin (Idamycin)
yes no

111 Total dose: _____ mg

112 Date started: __ __ __ __ - __ __- __ __

113 Rubidazone
Yes No

114 Total dose: _____ mg

115 Date started: __ __ __ __ - __ __- __ __

116 Other anthracycline
Yes No

117 Specify other anthracycline: _____

118 Total dose: _____ mg

119 Date started: __ __ __ __ - __ __- __ __

120 Bleomycin (BLM, Blenoxane)
yes no

121 Total dose: _____ mg

122 Date started: __ __ __ __ - __ __- __ __

123 Busulfan (Myleran)
Yes No

124 Total dose: _____ mg

125 Date started: __ __ __ __ - __ __- __ __

126 Specify administration
Oral IV Both

127 Carboplatin
yes no

128 Total dose: _____ mg

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day 20 Year | Infusion Date: Month Day 20 Year | CIBMTR Center Number:

Form 4000 R5.0: Cellular Therapy Essential Data Pre-Infusion Form

Center: CRID:

129 Date started: __ __ __ __ - __ __- __ __

130 Were pharmacokinetics performed to determine drug dosing?

Yes No

131 Specify the target AUC: _____ mg/mL/minute

132 Cisplatin (Platinol, CDDP)

yes no

133 Total dose: _____ mg

134 Date started: __ __ __ __ - __ __- __ __

135 Cladribine (2-CdA, Leustatin)

yes no

136 Total dose: _____ mg

137 Date started: __ __ __ __ - __ __- __ __

138 Corticosteroids

yes no

139 Methylprednisolone (Solu-Medrol)

Yes No

140 Total dose: _____ mg

141 Date started: __ __ __ __ - __ __- __ __

142 Prednisone

Yes No

143 Total dose: _____ mg

144 Date started: __ __ __ __ - __ __- __ __

145 Dexamethasone

yes no

146 Total dose: _____ mg

147 Date started: __ __ __ __ - __ __- __ __

148 Other corticosteroid

Yes No

149 Specify other corticosteroid: _____

150 Total dose: _____ mg

151 Date started: __ __ __ __ - __ __- __ __

152 Cyclophosphamide (Cytoxan)

yes no

153 Total dose: _____ mg

154 Date started: __ __ __ __ - __ __- __ __

155 Cytarabine (Ara-C)

yes no

156 Total dose: _____ mg

157 Date started: __ __ __ __ - __ __- __ __

158 Etoposide (VP-16, VePesid)

yes no

159 Total dose: _____ mg

160 Date started: __ __ __ __ - __ __- __ __

161 Fludarabine (Fludara)

yes no

162 Total dose: _____ mg

163 Date started: __ __ __ __ - __ __- __ __

164 Ifosfamide (Ifex)

yes no

165 Total dose: _____ mg

166 Date started: __ __ __ __ - __ __- __ __

167 Intrathecal therapy (chemotherapy)

yes no

168 Intrathecal cytarabine (IT Ara-C)

Yes No

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day 20 Year | Infusion Date: Month Day 20 Year | CIBMTR Center Number:

Form 4000 R5.0: Cellular Therapy Essential Data Pre-Infusion Form

Center: CRID:

169 Total dose: _____ mg

170 Date started: __ __ __ __ - __ __- __ __

171 Intrathecal methotrexate (IT MTX)

○ yes ○ no

172 Total dose: _____ mg

173 Date started: __ __ __ __ - __ __- __ __

174 Intrathecal thiotepa

○ Yes ○ No

175 Total dose: _____ mg

176 Date started: __ __ __ __ - __ __- __ __

177 Other intrathecal drug

○ Yes ○ No

178 Specify other intrathecal drug: _____

179 Total dose: _____ mg

180 Date started: __ __ __ __ - __ __- __ __

181 Melphalan (L-PAM, Alkeran)

○ yes ○ no

182 Total dose: _____ mg

183 Date started: __ __ __ __ - __ __- __ __

184 Specify administration

○ Oral ○ IV ○ Both

185 Mitoxantrone (Novantrone)

○ yes ○ no

186 Total dose: _____ mg

187 Date started: __ __ __ __ - __ __- __ __

188 Monoclonal antibody (mAb)

○ Yes ○ No

189 Radio labeled mAb

○ Yes ○ No

190 Total dose of radioactive component: _____ ○ mCi ○ MBq

191 Date started: __ __ __ __ - __ __- __ __

Specify radio labeled mAb:

192 Tositumomab (Bexxar)

○ yes ○ no

193 Ibritumomab tiuxetan (Zevalin)

○ yes ○ no

194 Other radio labeled mAb

○ Yes ○ No

195 Specify other radio labeled mAb: _____

196 Alemtuzumab (Campath)

○ yes ○ no

197 Total dose: _____ mg

198 Date started: __ __ __ __ - __ __- __ __

199 Rituximab (Rituxan, anti CD20)

○ yes ○ no

200 Total dose: _____ mg

201 Date started: __ __ __ __ - __ __- __ __

202 Gemtuzumab (Mylotarg, anti-CD33)

○ yes ○ no

203 Total dose: _____ mg

204 Date started: __ __ __ __ - __ __- __ __

205 Other 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.

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day 20 Year | Infusion Date: Month Day 20 Year | CIBMTR Center Number:

Form 4000 R5.0: Cellular Therapy Essential Data Pre-Infusion Form

Center: CRID:

206 Specify other mAb: _____

207 Total dose: _____ mg

208 Date started: __ __ __ __ - __ __ - __ __

209 Nitrosourea

○ Yes ○ No

210 Carmustine (BCNU, Gliadel)

○ yes ○ no

211 Total dose: _____ mg

212 Date started: __ __ __ __ - __ __ - __ __

213 CCNU (Lomustine)

○ Yes ○ No

214 Total dose: _____ mg

215 Date started: __ __ __ __ - __ __ - __ __

216 Other nitrosourea

○ Yes ○ No

217 Specify other nitrosourea: _____

218 Total dose: _____ mg

219 Date started: __ __ __ __ - __ __ - __ __

220 Paclitaxel (Taxol, Xyotax)

○ Yes ○ No

221 Total dose: _____ mg

222 Date started: __ __ __ __ - __ __ - __ __

223 Teniposide (VM26)

○ yes ○ no

224 Total dose: _____ mg

225 Date started: __ __ __ __ - __ __ - __ __

226 Thiotepa

○ Yes ○ No

227 Total dose: _____ mg

228 Date started: __ __ __ __ - __ __ - __ __

229 Treosulfan

○ Yes ○ No

230 Total dose: _____ mg

231 Date started: __ __ __ __ - __ __ - __ __

232 Tyrosine kinase inhibitors (TKI)

○ yes ○ no

233 Dasatinib (Sprycel)

○ yes ○ no

234 Total dose: _____ mg

235 Date started: __ __ __ __ - __ __ - __ __

236 Imatinib mesylate (STI571, Gleevec)

○ yes ○ no

237 Total dose: _____ mg

238 Date started: __ __ __ __ - __ __ - __ __

239 Nilotinib (AMN107, Tasigna)

○ yes ○ no

240 Total dose: _____ mg

241 Date started: __ __ __ __ - __ __ - __ __

242 Other tyrosine kinase inhibitor

○ Yes ○ No

243 Specify other tyrosine kinase inhibitor: _____

244 Total dose: _____ mg

245 Date started: __ __ __ __ - __ __ - __ __

246 Other drug

○ 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.

Form 4000 R5.0: Cellular Therapy Essential Data Pre-Infusion Form

Center: CRID:

247 Specify other drug: _____

248 Total dose: _____ mg

249 Date started: __ __ __ __ - __ __- __ __

Functional Status — Questions: 250 - 252

Specify the functional status of the recipient immediately prior to the cellular therapy:

250 What scale was used to determine the recipient's functional status prior to the cellular therapy

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

251 Karnofsky Scale (recipient age ≥ 16 years) _____

252 Lansky Scale (recipient age ≥ 1 and < 16 years) _____

Comorbid Conditions — Questions: 253 - 311

This section to be completed for malignant hematologic disorders and solid tumor indications.

253 Were there clinically significant co-existing diseases or organ impairment at time of patient assessment prior to preparative regimen? Source: Blood, 2005 Oct 15;106(8):2912-2919

○ yes ○ no

254 Arrhythmia **- For example, any history of atrial fibrillation or flutter, sick sinus syndrome, or ventricular arrhythmias requiring treatment**

○ yes ○ no ○ Unknown

255 Cardiac **- Any history of coronary artery disease (one or more vessel-coronary artery stenosis requiring medical treatment, stent, or bypass graft), congestive heart failure, myocardial infarction, OR ejection fraction ≤ 50% on the most recent test**

○ yes ○ no ○ Unknown

256 Cerebrovascular disease **- Any history of transient ischemic attack, subarachnoid hemorrhage or cerebrovascular accident**

○ yes ○ no ○ Unknown

257 Diabetes **- Requiring treatment with insulin or oral hypoglycemics in the last 4 weeks but not diet alone**

○ yes ○ no ○ Unknown

258 Heart valve disease **- Except asymptomatic mitral valve prolapse**

○ yes ○ no ○ Unknown

259 Hepatic, mild **- Chronic hepatitis, bilirubin > upper limit of normal to 1.5 × upper limit of normal, or AST/ALT > upper limit of normal to 2.5 × upper limit of normal at the time of transplant OR any history of hepatitis B or hepatitis C infection**

○ yes ○ no ○ Unknown

260 Hepatic, moderate / severe **- Liver cirrhosis, bilirubin > 1.5 × upper limit of normal, or AST/ALT > 2.5 × upper limit of normal**

○ yes ○ no ○ Unknown

261 Infection **- For example, documented infection, fever of unknown origin, or pulmonary nodules requiring continuation of antimicrobial treatment after day 0**

○ yes ○ no ○ Unknown

262 Inflammatory bowel disease **- Any history of Crohn's disease or ulcerative colitis requiring treatment**

○ yes ○ no ○ Unknown

263 Obesity **- Patients with a body mass index > 35 kg/m^2 prior to the start of conditioning**

○ yes ○ no ○ Unknown

264 Peptic ulcer **- Any history of peptic ulcer confirmed by endoscopy and requiring treatment**

○ yes ○ no ○ Unknown

265 Psychiatric disturbance **- For example, depression, anxiety, bipolar disorder or schizophrenia requiring psychiatric consult or treatment in the last 4 weeks**

○ yes ○ no ○ Unknown

266 Pulmonary, moderate **- Corrected diffusion capacity of carbon monoxide and/or FEV_1 66-80% or dyspnea on slight activity at transplant**

○ yes ○ no ○ Unknown

267 Pulmonary, severe **- Corrected diffusion capacity of carbon monoxide and/or FEV_1 ≤ 65% or dyspnea at rest or requiring oxygen at transplant**

○ yes ○ no ○ Unknown

268 Renal, moderate / severe **- Serum creatinine > 2 mg/dL or > 177 µmol/L or on dialysis at transplant, OR prior renal transplantation**

○ yes ○ no ○ Unknown

269 Rheumatologic **- For example, any history of systemic lupus erythmatosis, rheumatoid arthritis, polymyositis, mixed connective tissue disease, or polymyalgia rheumatica requiring treatment (do NOT include degenerative joint disease, osteoarthritis)**

○ yes ○ no ○ Unknown

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day 20 Year | Infusion Date: Month Day 20 Year | CIBMTR Center Number:

Form 4000 R5.0: Cellular Therapy Essential Data Pre-Infusion Form

Center: CRID:

270 Solid tumor, prior **- Treated at any time point in the patient's past history, excluding non-melanoma skin cancer, leukemia, lymphoma or multiple myeloma**
yes no Unknown

271 Breast cancer
yes no

272 Year of diagnosis: _____

273 Central nervous system (CNS) malignancy (glioblastoma, astrocytoma)
yes no

274 Year of diagnosis: _____

275 Gastrointestinal malignancy (colon, rectum, stomach, pancreas, intestine)
yes no

276 Year of diagnosis: _____

277 Genitourinary malignancy (kidney, bladder, ovary, testicle, genitalia, uterus, cervix)
yes no

278 Year of diagnosis: _____

279 Lung cancer
yes no

280 Year of diagnosis: _____

281 Melanoma
yes no

282 Year of diagnosis: _____

283 Oropharyngeal cancer (tongue, buccal mucosa)
yes no

284 Year of diagnosis: _____

285 Sarcoma
yes no

286 Year of diagnosis: _____

287 Thyroid cancer
yes no

288 Year of diagnosis: _____

289 Other co-morbid condition
yes no Unknown

290 Specify other co-morbid condition: _____

291 Was there a history of malignancy (hematologic or non-melanoma skin cancer) other than the primary disease for which this infusion is being performed?
yes no

Specify which malignancy(ies) occurred:

292 Acute myeloid leukemia (AML / ANLL)
yes no

293 Year of diagnosis: _____

294 Other leukemia, including ALL
yes no

295 Year of diagnosis: _____

296 Specify leukemia: _____

297 Clonal cytogenetic abnormality without leukemia or MDS
yes no

298 Year of diagnosis: _____

299 Hodgkin disease
yes no

300 Year of diagnosis: _____

301 Lymphoma or lymphoproliferative disease
yes no

302 Year of diagnosis: _____

303 Was the tumor EBV positive?
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.

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day 20 Year | Infusion Date: Month Day 20 Year | CIBMTR Center Number:

Form 4000 R5.0: Cellular Therapy Essential Data Pre-Infusion Form

Center: CRID:

304 Other skin malignancy (basal cell, squamous)

yes no

305 Year of diagnosis: _____

306 Specify other skin malignancy: _____

307 Myelodysplasia (MDS) / myeloproliferative (MPN) disorder

yes no

308 Year of diagnosis: _____

309 Other prior malignancy

yes no

310 Year of diagnosis: _____

311 Specify other prior malignancy: _____

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.