Form 4100 R4.0: Cellular Therapy Essential Data Follow-Up Form

Center: CRID:

Key Fields

Sequence Number: _____

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

CIBMTR Center Number: _____

CIBMTR Research ID: _____

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

Visit

○ 100 day ○ 6 months ○ 1 year ○ 2 years ○ > 2 years,

Specify: _____

Product

Questions: 1 - 1

1 Name of product (for most recent cell therapy infusion)

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

Survival

Questions: 2 - 3

2 Date of actual contact with the recipient to determine medical status for this follow-up report: __ __ __ __ - __ __- __ __

3 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. Complete a Form 2900 - Recipient Death Data.**

Subsequent Cellular Infusions

Questions: 4 - 8

All additional cellular therapy infusions given for the same indication per protocol require a separate infusion form and should be reported on the Form 4000 for this course of cellular therapy. If a cellular therapy was administered for treatment of a different indication, or in response to disease progression / no response, a new Form 4000 (Pre-CTED) must be completed.

4 Has the recipient received a new course of cellular therapy (unplanned) since the date of last report?

○ Yes ○ No

5 Specify the reason for which cellular therapy was given

- ○ Failure to respond or in response to disease assessment
- ○ New indication

6 Date of cellular therapy: __ __ __ __ - __ __- __ __ **Also complete Cellular Therapy Essential Data Pre-Infusion Form 4000**

7 Did the recipient receive an HCT since the date of last report?

- ○ Yes **- Also complete Pre-TED Form 2400 for the subsequent HCT**
- ○ No

8 Date of HCT: __ __ __ __ - __ __- __ __

Best Response to Cellular Therapy

Questions: 9 - 11

9 What was the best response to the cellular therapy?

- ○ Complete response
- ○ Normalization of organ function
- ○ Partial response
- ○ Partial normalization of organ function
- ○ No response
- ○ Disease progression or worsening of organ function
- ○ Not applicable (e.g. infection prophylaxis)
- ○ Unknown

10 Was the date of best response previously reported?

○ yes ○ no

11 Date response established: __ __ __ __ - __ __- __ __

Disease Relapse or Progression

Questions: 12 - 13

12 Was a disease relapse or progression detected since the date of last report?

○ yes ○ no

13 Date documented: __ __ __ __ - __ __- __ __

Peripheral Blood Count Recovery

Questions: 14 - 17

14 Was there evidence of initial 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 lymphodepleting therapy / no lymphodepleting therapy given)
- ○ Previously reported (recipient's initial recovery was recorded on a previous report)

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

16 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 at any time after the start of lymphodepleting therapy / no lymphodepleting therapy given
- ○ Previously reported - ≥ 20 x 10^9/L was achieved and reported previously

17 Date platelets ≥ 20 x 10^9/L: __ __ __ __ - __ __- __ __

Current Hematologic Findings

Questions: 18 - 32

18 Date of most recent complete blood count: __ __ __ __ - __ __- __ __

19 WBC

○ Known ○ Unknown

20 WBC: _____ ○ x 10^9/L (x 10^3/mm³) ○ x 10^6/L

21 Neutrophils

○ Known ○ Unknown

22 Neutrophils: _____ %

23 Lymphocytes

○ Known ○ Unknown

24 Lymphocytes: _____ %

25 Hemoglobin

○ Known ○ Unknown

26 Hemoglobin: _____ ○ g/dL ○ g/L ○ mmol/L

27 Hematocrit

○ Known ○ Unknown

28 Hematocrit: _____ %

29 Was RBC transfused ≤ 30 days before date of test?

○ Yes ○ No

30 Platelets

○ Known ○ Unknown

31 Platelets: _____ ○ x 10^9/L (x 10^3/mm³) ○ x 10^6/L

32 Were platelets transfused ≤ 7 days before date of test?

○ Yes ○ No

New Malignancy, Lymphoproliferative or Myeloproliferative Disease / Disorder

Questions: 33 - 33

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

33 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 **- Complete form 3500**
- ○ No
- ○ Previously reported (form 3500 has already been submitted)

Persistence of Cells

Questions: 34 - 55

This section pertains to the evaluation of persistence of a cellular product in the recipient.

34 Were tests performed to detect persistence of the cellular product since the date of last report?

○ Yes ○ No

35 Was persistence evaluated by molecular assay? (e.g. PCR)

○ Yes ○ No

36 Date sample collected: __ __ __ __ - __ __- __ __

37 Specify the cell source
○ Bone marrow ○ Peripheral blood ○ Tumor ○ Other source

38 Specify other cell source: _____

39 Were the infused cells detected?
○ Yes ○ No

40 Was persistence evaluated by flow cytometry testing? (immunophenotyping)
○ Yes ○ No

41 Date sample collected: __ __ __ __ - __ __- __ __

42 Specify the cell source
○ Bone marrow ○ Peripheral blood ○ Tumor ○ Other source

43 Specify other cell source: _____

44 Were the infused cells detected?
○ Yes ○ No

45 Was persistence evaluated by immunohistochemistry?
○ Yes ○ No

46 Date sample collected: __ __ __ __ - __ __- __ __

47 Specify the cell source
○ Bone marrow ○ Peripheral blood ○ Tumor ○ Other source

48 Specify other cell source: _____

49 Were the infused cells detected?
○ Yes ○ No

50 Was persistence evaluated by other method?
○ Yes ○ No

51 Specify other method: _____

52 Date sample collected: __ __ __ __ - __ __- __ __

53 Specify the cell source
○ Bone marrow ○ Peripheral blood ○ Tumor ○ Other source

54 Specify other cell source: _____

55 Were the infused cells detected?
○ Yes ○ No

Graft vs. Host Disease

Questions: 56 - 75

This section is for allogeneic infusions only. If this was an autologous infusion, continue to question 76.

56 Did acute GVHD develop since the date of last report?
○ Yes ○ No ○ Unknown

57 Date of acute GVHD diagnosis: __ __ __ __ - __ __- __ __

58 Did acute GVHD persist since the date of last report?
○ Yes ○ No ○ Unknown

59 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:

60 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

61 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

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

63 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)

64 Other site(s) involved with acute GVHD
○ Yes ○ No

65 Specify other site(s): _____

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

66 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 billirubin > 15 mg/dL
- ○ Not applicable (acute GVHD present but grade is not applicable)

67 Date maximum overall grade of acute GVHD: __ __ __ __ - __ __- __ __

68 Did chronic GVHD develop since the date of last report?
○ Yes ○ No ○ Unknown

69 Date of chronic GVHD diagnosis: __ __ __ __ - __ __- __ __ ☐ Date estimated

70 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:

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

72 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 < 5 mm wetting; or
  - involvement of minor salivary glands or oral mucosa demonstrated on labial biopsy; or
  - involvement of any other target organ

73 Date of maximum grade of chronic GVHD: __ __ __ __ - __ __- __ __

74 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

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

Toxicities
Questions: 76 - 187

76 Did the recipient develop Cytokine Release Syndrome (CRS) since the date of last report?
○ Yes ○ No

77 Date of diagnosis: __ __ __ __ - __ __- __ __

78 Was therapy given? (for CRS)
○ yes ○ no

Specify therapy given for CRS:

79 Specify therapy given for CRS (check all that apply)
- ☐ Corticosteroids
- ☐ Siltuximab
- ☐ Tocilizumab
- ☐ Other therapy

80 Specify other therapy: _____

Symptoms

81 Fevers (≥ 100.4° F or ≥ 38° C)

○ Yes ○ No ○ Unknown

82 Date of onset: __ __ __ __ - __ __- __ __

83 Hypotension requiring therapy

○ Yes ○ No ○ Unknown

84 Date of onset: __ __ __ __ - __ __- __ __

Specify therapy given for hypotension:

85 Intravenous fluids

○ Yes ○ No ○ Unknown

86 Vasopressor(s)

○ Yes ○ No ○ Unknown

87 Specify the number of vasopressors used for therapy

○ 1 ○ ≥2 ○ Unknown

88 Other therapy

○ yes ○ no ○ Unknown

89 Specify other therapy: _____

90 Was hypotension controlled with therapy?

○ Yes ○ No ○ Unknown

91 Hypoxia requiring minimal supplemental oxygen (FiO2 <40%)

○ Yes ○ No ○ Unknown

92 Date of onset: __ __ __ __ - __ __- __ __

93 Hypoxia requiring more than minimal supplemental oxygen (FiO2 ≥40%)

○ Yes ○ No ○ Unknown

94 Date of onset: __ __ __ __ - __ __- __ __

95 Was positive pressure ventilatory support required? (CPAP, BiPAP, intubation and mechanical ventilation)

○ Yes ○ No ○ Unknown

96 Date started: __ __ __ __ - __ __- __ __

97 Did cytokine release syndrome resolve?

○ Yes ○ No

98 Date resolved: __ __ __ __ - __ __- __ __

Neurotoxicity

99 Neurotoxicity

○ Yes ○ No ○ Unknown

100 Date of onset: __ __ __ __ - __ __- __ __

Specify symptoms of neurotoxicity. Report the highest grade observed in this reporting period:

101 Was a CARTOX-10 neurologic assessment performed?

○ Yes ○ No ○ Unknown

102 What was the lowest CARTOX score?

○ 10
○ 7-9
○ 3-6
○ 0-2
○ Unable to be assessed

103 Depressed level of consciousness

○ Yes ○ No ○ Unknown

104 Dysphasia / aphasia

○ Yes ○ No ○ Unknown

105 Grade

○ 1
○ 2
○ 3 (aphasia)

106 Seizure

○ Yes ○ No ○ Unknown

107 Type

- ○ Complex partial
- ○ Generalized tonic-clonic
- ○ Non-convulsive status epilepticus
- ○ Simple partial
- ○ Status epilepticus
- ○ Other type
- ○ Unknown

108 Specify other type: _____

109 Severity

- ○ Grade 3 (Any clinical seizure focal or generalized that resolves rapidly; or Non-convulsive seizures on EEG that resolve with intervention)
- ○ Grade 4 (Life-threatening prolonged seizure (>5 min); or Repetitive clinical or electrical seizures without return to baseline in between)

110 Hemiparesis / paraparesis / other motor deficit

○ Yes ○ No ○ Unknown

111 Cerebral edema

○ Yes ○ No ○ Unknown

112 Grade

○ 3 ○ 4

113 Hallucinations

○ Yes ○ No ○ Unknown

114 Tremors

○ Yes ○ No ○ Unknown

115 Cerebral vascular accident (stroke)

○ Yes ○ No ○ Unknown

116 Date of onset: __ __ __ __ - __ __- __ __

117 Type

○ Hemorrhagic ○ Ischemic

118 Leukoencephalopathy

○ Yes ○ No ○ Unknown

Other Neurotoxicity Symptom(s) (1) — Questions: 119 - 120

119 Other symptom

○ Yes ○ No ○ Unknown

120 Specify other symptom: _____

121 Did neurotoxicity resolve?

○ Yes ○ No

122 Date resolved: __ __ __ __ - __ __- __ __

Specify therapy given for neurotoxicity:

123 Specify therapy given for neurotoxicity (check all that apply)

- ☐ Anti-epileptics
- ☐ Corticosteroids
- ☐ Other therapy

124 Specify other therapy: _____

Other toxicities

125 Hypogammaglobulinemia

○ Yes ○ No ○ Unknown

126 Date of onset: __ __ __ __ - __ __- __ __

127 Did hypogammaglobulinema resolve?

○ Yes ○ No

128 Date resolved: __ __ __ __ - __ __- __ __

129 Did recipient require immunoglobulin replacement therapy?

○ Yes ○ No

130 Is the recipient still requiring replacement therapy?

○ Yes ○ No

131 Tumor lysis syndrome

○ Yes ○ No ○ Unknown

132 Date of onset: __ __ __ __ - __ __ - __ __

133 Grade

○ 3 ○ 4 ○ 5

134 Other toxicity

○ Yes ○ No ○ Unknown

135 Specify other toxicity: _____

136 Date of onset: __ __ __ __ - __ __ - __ __

Specify if the recipient has developed any of the following since the date of last report:

137 Has the recipient developed any grade 3 organ toxicity?

○ Yes ○ No ○ Unknown

138 Gastrointestinal (GI)

○ Yes ○ No ○ Unknown

139 Date of onset: __ __ __ __ - __ __ - __ __

140 Heart

○ Yes ○ No ○ Unknown

141 Date of onset: __ __ __ __ - __ __ - __ __

142 Kidneys

○ Yes ○ No ○ Unknown

143 Date of onset: __ __ __ __ - __ __ - __ __

144 Liver

○ Yes ○ No ○ Unknown

145 Date of onset: __ __ __ __ - __ __ - __ __

146 Lungs

○ Yes ○ No ○ Unknown

147 Date of onset: __ __ __ __ - __ __ - __ __

148 Musculoskeletal

○ Yes ○ No ○ Unknown

149 Date of onset: __ __ __ __ - __ __ - __ __

150 Neurologic

○ Yes ○ No ○ Unknown

151 Date of onset: __ __ __ __ - __ __ - __ __

152 Other organ

○ Yes ○ No ○ Unknown

153 Date of onset: __ __ __ __ - __ __ - __ __

154 Specify other organ: _____

155 Has the recipient developed any grade 4 organ toxicity?

○ Yes ○ No ○ Unknown

156 Gastrointestinal (GI)

○ Yes ○ No ○ Unknown

157 Date of onset: __ __ __ __ - __ __ - __ __

158 Heart

○ Yes ○ No ○ Unknown

159 Date of onset: __ __ __ __ - __ __ - __ __

160 Kidneys

○ Yes ○ No ○ Unknown

161 Date of onset: __ __ __ __ - __ __ - __ __

162 Liver

○ Yes ○ No ○ Unknown

163 Date of onset: __ __ __ __ - __ __ - __ __

164 Lungs

○ Yes ○ No ○ Unknown

165 Date of onset: __ __ __ __ - __ __ - __ __

166 Musculoskeletal

○ Yes ○ No ○ Unknown

167 Date of onset: __ __ __ __ - __ __ - __ __

168 Neurologic

○ Yes ○ No ○ Unknown

169 Date of onset: __ __ __ __ - __ __ - __ __

170 Other organ

○ Yes ○ No ○ Unknown

171 Date of onset: __ __ __ __ - __ __ - __ __

172 Specify other organ: _____

Specify the maximum lab results since the date of last report:

173 Interleukin-6
○ Known ○ Unknown

174 _____ pg/mL

175 Date sample collected: __ __ __ __ - __ __- __ __

176 Interferon gamma IFN γ
○ Known ○ Unknown

177 _____ IU/mL

178 Date sample collected: __ __ __ __ - __ __- __ __

179 Soluble interleukin-2 receptor α (sIL2RA or soluble CD25)
○ Known ○ Unknown

180 _____ U/mL

181 Date sample collected: __ __ __ __ - __ __- __ __

182 Total serum ferritin
○ Known ○ Unknown

183 _____ ng/mL(µg/L)

184 Date sample collected: __ __ __ __ - __ __- __ __

185 C-reactive protein
○ Known ○ Unknown

186 _____ mg/dL

187 Date sample collected: __ __ __ __ - __ __- __ __

Infection

Questions: 188 - 192

188 Did the recipient develop a clinically significant infection since the date of last report?
○ Yes ○ No

Infection (1)

Questions: 189 - 192

Report each infection organism, site, and date of diagnosis

189 Organism _____

190 Specify other organism: _____

191 Site (check all that apply)

- ☐ Blood
- ☐ Bone
- ☐ CNS
- ☐ Eyes
- ☐ Genital area
- ☐ GI tract, Lower
- ☐ GI tract, Upper
- ☐ Joints
- ☐ Liver/Spleen
- ☐ Lung
- ☐ Sinus and/or Upper respiratory tract
- ☐ Skin, cellulitis
- ☐ Skin, necrotizing fasciitis
- ☐ Urinary tract, Lower
- ☐ Urinary tract, Upper

192 Date of diagnosis: __ __ __ __ - __ __- __ __

Functional Status

Questions: 193 - 194

193 Was the recipient pregnant at any time in this reporting period? **(Female only)**
○ Yes **- Complete form 3501**
○ No
○ Unknown
○ Previously reported (form 3501 already submitted for this event)

194 Was the recipient's female partner pregnant at any time in this reporting period? **(Male only)**

- ○ Yes **- Complete form 3501**
- ○ No
- ○ Unknown
- ○ Previously reported (form 3501 already submitted for this event)

First Name: _____

Last Name: _____

E-mail address: _____

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