Post-Transplant Essential Data

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number: ___ ___ ___ ___ ___
CIBMTR Research ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Event date: ___ ___ ___ ___ - ___ ___ - ___ ___

YYYY  MM  DD

Visit:

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

Specify: ___ ___

Survival

1. Date of actual contact with the recipient to determine medical status for this follow-up report:
2. 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 - Go to question 7
- Dead - Answers to subsequent questions should reflect clinical status between the date of last report and immediately prior to death - Go to question 3

3. Primary cause of death

- Recurrence / persistence / progression of disease for which the HCT or cellular therapy was performed – Go to question 5
- Acute GVHD – Go to question 5
- Chronic GVHD – Go to question 5
- Graft rejection or failure – Go to question 5
- Cytokine release syndrome – Go to question 5

Infection

- Infection, organism not identified – Go to question 5
- Bacterial infection – Go to question 5
- Fungal infection – Go to question 5
- Viral infection – Go to question 5
- COVID-19 (SARS-CoV-2) – Go to question 5
- Protozoal infection – Go to question 5
- Other infection – Go to question 4

Pulmonary

- Idiopathic pneumonia syndrome (IPS) – Go to question 5
- Pneumonitis due to Cytomegalovirus (CMV) – Go to question 5
- Pneumonitis due to other virus – Go to question 5
- Other pulmonary syndrome (excluding pulmonary hemorrhage) – Go to question 4
- Diffuse alveolar damage (without hemorrhage) – Go to question 5
- Acute respiratory distress syndrome (ARDS) (other than IPS) – Go to question 5

Organ failure (not due to GVHD or infection)

- Liver failure (not VOD) – Go to question 5
- Veno-occlusive disease (VOD) / sinusoidal obstruction syndrome (SOS) – Go to question 5
- Cardiac failure – Go to question 5
Pulmonary failure – Go to question 5
Central nervous system (CNS) failure – Go to question 5
Renal failure – Go to question 5
Gastrointestinal (GI) failure (not liver) – Go to question 5
Multiple organ failure – Go to question 4
Other organ failure – Go to question 4

Malignancy
New malignancy (post-HCT or post-cellular therapy) – Go to question 5
Prior malignancy (malignancy initially diagnosed prior to HCT or cellular therapy, other than the malignancy for which the HCT or cellular therapy was performed) – Go to question 5

Hemorrhage
Pulmonary hemorrhage – Go to question 5
Diffuse alveolar hemorrhage (DAH) – Go to question 5
Intracranial hemorrhage – Go to question 5
Gastrointestinal hemorrhage – Go to question 5
Hemorrhagic cystitis – Go to question 5
Other hemorrhage – Go to question 4

Vascular
Thromboembolic – Go to question 5
Disseminated intravascular coagulation (DIC) – Go to question 5
Thrombotic microangiopathy (TMA) (Thrombotic thrombocytopenic purpura (TTP)/Hemolytic Uremic Syndrome (HUS)) – Go to question 5
Other vascular - Go to question 4

Other
Accidental death – Go to question 5
Suicide – Go to question 5
Other cause - Go to question 4

4. Specify: _______________________________________

5. Contributing cause of death (check all that apply)
Recurrence / persistence / progression of disease for which the HCT or cellular therapy was performed – Go to question 7
Acute GVHD – Go to question 7
• Chronic GVHD – Go to question 7
• Graft rejection or failure – Go to question 7
• Cytokine release syndrome – Go to question 7

Infection
• Infection, organism not identified – Go to question 7
• Bacterial infection – Go to question 7
• Fungal infection – Go to question 7
• Viral infection – Go to question 7
• COVID-19 (SARS-CoV-2) – Go to question 7
• Protozoal infection – Go to question 7
• Other infection – Go to question 6

Pulmonary
• Idiopathic pneumonia syndrome (IPS) – Go to question 7
• Pneumonitis due to Cytomegalovirus (CMV) – Go to question 7
• Pneumonitis due to other virus – Go to question 7
• Other pulmonary syndrome (excluding pulmonary hemorrhage) – Go to question 6
• Diffuse alveolar damage (excluding pulmonary hemorrhage) – Go to question 7
• Acute respiratory distress syndrome (ARDS) (other than IPS) – Go to question 7

Organ failure (not due to GVHD or infection)
• Liver failure (not VOD) – Go to question 7
• Veno-occlusive disease (VOD) / sinusoidal obstruction syndrome (SOS) – Go to question 7
• Cardiac failure – Go to question 7
• Pulmonary failure – Go to question 7
• Central nervous system (CNS) failure – Go to question 7
• Renal failure – Go to question 7
• Gastrointestinal (GI) failure (not liver) – Go to question 7
• Multiple organ failure – Go to question 6
• Other organ failure – Go to question 6

Malignancy
• New malignancy (post-HCT or post-cellular therapy) – Go to question 7
• Prior malignancy (malignancy initially diagnosed prior to HCT or cellular therapy, other than the malignancy for which the HCT or cellular therapy was performed) – Go to question 7

Hemorrhage
6. Specify: _____________________________________________________________

7. Did the recipient receive a subsequent HCT since the date of last report?
   - Yes – Go to question 8
   - No - Go to question 12

8. Date of subsequent HCT: ___ ___ ___ ___ — ___ ___ — ___ ___
    YYYY MM DD

9. What was the indication for subsequent HCT?
   - Graft failure / insufficient hematopoietic recovery - Allogeneic HCTs Complete a Pre-TED Form 2400 for the subsequent HCT – Go to question 11
   - Persistent primary disease – Complete a Pre-TED Form 2400 for the subsequent HCT – Go to question 11
   - Recurrent primary disease – Complete a Pre-TED Form 2400 for the subsequent HCT – Go to question 11
   - Planned subsequent HCT, per protocol – Complete a Pre-TED Form 2400 for the subsequent HCT – Go to question 11
☐ New malignancy (including PTLD and EBV lymphoma) – Complete a Pre-TED Form 2400 for the subsequent HCT – Go to question 11
☐ Insufficient chimerism – Complete a Pre-TED Form 2400 for the subsequent HCT – Go to question 11
☐ Other – Complete a Pre-TED Form 2400 for the subsequent HCT – Go to question 10

10. Specify other indication: ____________________

11. Source of HSCs (check all that apply)
   ☐ Allogeneic, related
   ☐ Allogeneic, unrelated
   ☐ Autologous

12. Has the recipient received a cellular therapy since the date of last report? (e.g. CAR-T, DCI)
   ☐ Yes – Go to question 13 – Also complete Cellular Therapy Essential Data Pre-Infusion Form 4000
   ☐ No – Go to question 14

13. Date of cellular therapy: _____ _____ _____ – _____ _____
    YYYY MM DD

Initial ANC Recovery

14. Was there evidence of initial hematopoietic recovery?
   ☐ Yes (ANC ≥ 500/mm³ achieved and sustained for 3 lab values) – Go to question 15
   ☐ No (ANC ≥ 500/mm³ was not achieved) – Go to question 16
   ☐ Not applicable (ANC never dropped below 500/mm³ at any time after the start of the preparative regimen) – Go to question 16
   ☐ Previously reported (recipient’s initial hematopoietic recovery was recorded on a previous report) – Go to question 16

15. Date ANC ≥ 500/mm³ (first of 3 lab values): _____ _____ _____ – _____ _____
    YYYY MM DD

16. Did late graft failure occur?
   ☐ Yes
   ☐ No
Initial Platelet Recovery

(Optional for Non-U.S. Centers)

17. Was an initial platelet count ≥ 20 x 10^9/L achieved?

☐ Yes – Go to question 18
☐ No – Go to question 19
☐ Not applicable (Platelet count never dropped below 20 x 10^9/L) – Go to question 19
☐ Previously reported – (≥ 20 x 10^9/L was achieved and reported previously) – Go to question 19

18. Date platelets ≥ 20 x 10^9/L: ___ ___ ___ ___ — ___ ___ — ___ ___ – Go to question 19

YYYY MM DD

Graft vs. Host Disease

If an allogeneic donor was used for the recipient’s HCT or cellular therapy, report all graft-versus-host disease occurring in this reporting period. If an allogeneic donor was not used, continue to Liver Toxicity Prophylaxis, question 45.

19. Did acute GVHD develop since the date of last report?

☐ Yes – Go to question 20
☐ No – Go to question 21
☐ Unknown – Go to question 21

20. Date of acute GVHD diagnosis: ___ ___ ___ ___ — ___ ___ — ___ ___ – Go to question 22

YYYY MM DD

21. Did acute GVHD persist since the date of last report?

☐ Yes – Go to question 29
☐ No – Go to question 37
☐ Unknown – Go to question 37

22. 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 or vomiting
☐ 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:

23. 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

24. 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

25. Upper intestinal tract:
- Stage 0 – no persistent nausea or vomiting
- Stage 1 – persistent nausea or vomiting

26. 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)

27. Other site(s) involved with acute GVHD
- Yes – Go to question 28
- No – Go to question 29

28. Specify other site(s): _________________________________
Specify the maximum overall grade and organ staging of acute GVHD since the date of last report

29. 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 or vomiting
   - 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 cannot be graded)

30. Date maximum overall grade of acute GVHD: ___ ___ ___ ___ - ___ ___ - ___ ___

31. 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

32. 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

33. Upper intestinal tract:
   - Stage 0 – no persistent nausea or vomiting
   - Stage 1 – persistent nausea or vomiting

34. 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)

35. Other site(s) involved with acute GVHD
   □ Yes – Go to question 36
   □ No – Go to question 37

36. Specify other site(s): ________________________________

37. Did chronic GVHD develop since the date of last report?
   □ Yes – Go to questions 38
   □ No - Go to question 39
   □ Unknown – Go to question 39

38. Date of chronic GVHD diagnosis: ___ ___ ___ ___ — ___ ___ — ___ ___ □ Date estimated – Go to questions 40
   YYYY MM DD

39. Did chronic GVHD persist since the date of last report?
   □ Yes – Go to questions 40
   □ No - Go to question 43
   □ Unknown – Go to question 43

   Specify the maximum grade of chronic GVHD since the date of last report:

40. Maximum grade of chronic GVHD (according to best clinical judgment)
   □ Mild
   □ Moderate
   □ Severe
   □ Unknown

41. 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

42. Date of maximum grade of chronic GVHD: _______ ___ - ___ - ___
    YYYY    MM     DD

43. Is the recipient still taking systemic steroids? (Do not report steroids for adrenal insufficiency, or steroid dose ≤10 mg/day for adults, <0.1 mg/kg/day for children)
   ☐ Yes
   ☐ No
   ☐ Not applicable
   ☐ Unknown

44. Is the recipient still taking (non-steroid) immunosuppressive agents (including PUVA) for GVHD?
   ☐ Yes
   ☐ No
   ☐ Not applicable
   ☐ Unknown

Liver Toxicity Prophylaxis

45. Was specific therapy used to prevent liver toxicity?
   ☐ Yes – Go to question 46
   ☐ No – Go to question 48

46. Specify therapy (check all that apply)
   ☐ Defibrotide – Go to question 48
   ☐ N-acetylcysteine – Go to question 48
   ☐ Tissue plasminogen activator (TPA) – Go to question 48
   ☐ Urosodiol – Go to question 48
   ☐ Other – Go to question 47

47. Specify other therapy: _____________________________________________
Veno-occlusive disease (VOD) / Sinusoidal obstruction syndrome (SOS)

Specify if the recipient developed VOD / SOS since the date of last report:

48. Did veno-occlusive disease (VOD) / sinusoidal obstruction syndrome (SOS) develop since the date of last report?
   □ Yes – Go to question 49
   □ No – Go to question 50

49. Date of diagnosis: ___ ___ ___ ___ - ___ ___ - ___ ___
    YYYY MM DD

Infection

Copy and complete questions 50-51 to report more than one infection.

50. Did the recipient develop COVID-19 (SARS-CoV-2) since the date of last report?
   □ Yes – Go to question 51
   □ No – Go to question 52

51. Date of diagnosis: ___ ___ ___ ___ - ___ ___ - ___ ___
    YYYY MM DD

52. Was a vaccine for COVID-19 (SARS-CoV-2) received?
   □ Yes – Go to question 53
   □ No – Go to question 57
   □ Unknown – Go to question 57

Copy and complete questions 53-56 to report all vaccine doses received.

53. Specify vaccine brand
   □ AstraZeneca – Go to question 55
   □ Johnson & Johnson’s / Janssen – Go to question 55
   □ Moderna – Go to question 55
   □ Novavax – Go to question 55
54. Specify other type: __________

55. Select dose(s) received
   - One dose (without planned second dose)
   - First dose (with planned second dose)
   - Second dose
   - Third dose
   - Booster dose

56. Date received: ____ ____ ____ — ____ — ____
    □ Date estimated
    YYYY   MM   DD

Copy and complete questions 53-56 to report all vaccine doses received.

New Malignancy, Lymphoproliferative or Myeloproliferative Disease / Disorder

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

57. 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 – Go to question 58
   - No – Go to question 65

Copy and complete questions 58-64 to report each new malignancy diagnosed since the date of last report. The submission of a pathology report or other supportive documentation for each reported new malignancy is strongly recommended.

58. Specify the new malignancy:
   - Acute myeloid leukemia (AML / ANLL) – Go to question 61
   - Other leukemia – Go to question 61
   - Myelodysplastic syndrome (MDS) – Go to question 61
   - Myeloproliferative neoplasm (MPN) – Go to question 61
   - Myelodysplasia / myeloproliferative neoplasm (MDS / MPN)– Go to question 61
□ Hodgkin lymphoma – Go to question 60
□ Non-Hodgkin lymphoma – Go to question 60
□ Post-transplant lymphoproliferative disorder (PTLD) – Go to question 60
□ Clonal cytogenetic abnormality without leukemia or MDS – Go to question 61
□ Uncontrolled proliferation of donor cells without malignant transformation – Go to question 61
□ Breast cancer – Go to question 61
□ Central nervous system (CNS) malignancy (e.g. glioblastoma, astrocytoma) – Go to question 61
□ Gastrointestinal malignancy (e.g. colon, rectum, stomach, pancreas, intestine) – Go to question 61
□ Genitourinary malignancy (e.g. kidney, bladder, ovary, testicle, genitalia, uterus, cervix) – Go to question 61
□ Lung cancer – Go to question 61
□ Melanoma – Go to question 61
□ Basal cell skin malignancy – Go to question 61
□ Squamous cell skin malignancy – Go to question 61
□ Oropharyngeal cancer (e.g. tongue, buccal mucosa) – Go to question 61
□ Sarcoma – Go to question 61
□ Thyroid cancer – Go to question 61
□ Other new malignancy – Go to question 59

59. Specify other new malignancy: ________________________________ - Go to question 61

60. Is the tumor EBV positive?
□ Yes
□ No

61. Date of diagnosis: ___ ___ ___ ___ — ___ ___ — ___ ___
    YYYY MM DD

62. Was documentation submitted to the CIBMTR? (e.g. pathology / autopsy report or other documentation)
□ Yes
□ No

63. Was the new malignancy donor / cell product derived?
□ Yes – Go to question 64
□ No – Go to question 64
□ Not done – Go to question 65
64. Was documentation submitted to the CIBMTR? *(e.g. cell origin evaluation (VNTR, cytogenetics, FISH))*

☐ Yes
☐ No

Chimerism Studies (Cord Blood Units, Beta Thalassemia, and Sickle Cell Disease Only)

This section relates to chimerism studies from allogeneic HCTs using cord blood units or for recipients whose primary disease is beta thalassemia or sickle cell disease. If this was an autologous HCT, or an allogeneic HCT using a bone marrow or PBSC product, or a different primary disease, continue to disease assessment.

65. Were chimerism studies performed since the date of last report?

☐ Yes – *Go to question 66*
☐ No – *Go to question 85*

66. Was documentation submitted to the CIBMTR? *(e.g. chimerism laboratory reports)*

☐ Yes
☐ No

67. Were chimerism studies assessed for more than one donor / multiple donors?

☐ Yes
☐ No

Provide date(s), method(s) and other information for all chimerism studies performed since the date of last report.

68. NMDP donor ID: _____________________________

69. NMDP cord blood unit ID: _____________________________

70. Registry donor ID: _____________________________

71. Non-NMDP cord blood unit ID: _____________________________

72. Global Registration Identifiers for Donors (GRID): _____________________________

73. Date of birth: (donor / infant) _______ _______ — _______ — _______ — **OR** — Age: (donor/infant) _______

☐ Months
☐ Years

*Note that this field is hidden in FormsNet3, as the GRID in Q72 should be utilized.*
74. Sex (Donor / infant)
   - Male
   - Female

75. Date sample collected: ___ ___ ___ ___ — ___ ___ — ___ ___
   YYYY MM DD

76. Method
   - Karyotyping for XX/XY – Go to question 78
   - Fluorescent in situ hybridization (FISH) for XX/XY – Go to question 78
   - Restriction fragment-length polymorphisms (RFLP) – Go to question 78
   - VNTR or STR, micro or mini satellite (also include AFLP) – Go to question 78
   - Other – Go to question 77

77. Specify: _________________________________

78. Cell source
   - Bone marrow
   - Peripheral blood

79. Cell type
   - Unsorted / whole – Go to question 81
   - Red blood cells – Go to question 83
   - Hematopoietic progenitor cells (CD34+ cells) – Go to question 83
   - Total mononuclear cells (lymphs & monos) – Go to question 83
   - T-cells (includes CD3+, CD4+, and/or CD8+) – Go to question 83
   - B-cells (includes CD19+ or CD20+) – Go to question 83
   - Granulocytes (includes CD33+ myeloid cells) – Go to question 83
   - NK cells (CD56+) – Go to question 83
   - Other – Go to question 80

80. Specify: _________________________________

81. Total cells examined: ___ ___ ___ ___ ___ ___

82. Number of donor cells: ___ ___ ___ ___ - Go to question 85
83. Were donor cells detected?
   - Yes - Go to question 84
   - No – Go to question 85

84. Percent donor cells: ___ ___ ___ %

Copy questions 68 – 84 if needed for multiple chimerism studies.

Disease Assessment at the Time of Best Response to HCT

85. Compared to the disease status prior to the preparative regimen, what was the best response to HCT since the date of the last report? (Include response to any therapy given for post-HCT maintenance or consolidation, but exclude any therapy given for relapsed, persistent, or progressive disease)
   - Continued complete remission (CCR) - For patients transplanted in CR- Go to question 108
   - Complete remission (CR) - Go to question 87
   - Not in complete remission - Go to question 86
   - Not evaluated - Go to question 108

86. Specify disease status if not in complete remission:
   - Disease detected - Go to question 89
   - No disease detected but incomplete evaluation to establish CR - Go to question 89

87. Was the date of best response previously reported?
   - Yes - Go to question 108
   - No - Go to question 88

88. Date assessed: ___ ___ ___ ___ — ___ ___ — ___ ___

Specify the method(s) used to assess the disease status at the time of best response:

89. Was the disease status assessed by molecular testing? (e.g. PCR)
   - Yes - Go to questions 90
   - No - Go to question 92
   - Not applicable - Go to question 92

90. Date assessed: ___ ___ ___ ___ — ___ ___ — ___ ___
91. Was disease detected?
   □ Yes
   □ No

92. Was the disease status assessed via flow cytometry?
   □ Yes - Go to question 93
   □ No - Go to question 95
   □ Not applicable - Go to question 95

93. Date assessed: ___ ___ ___ ___ — ___ ___ — ___ ___

94. Was disease detected?
   □ Yes
   □ No

95. Was the disease status assessed by cytogenetic testing? (karyotyping or FISH)
   □ Yes - Go to question 96
   □ No - Go to question 102
   □ Not applicable - Go to question 102

96. Was the disease status assessed via FISH?
   □ Yes - Go to questions 97
   □ No - Go to question 99
   □ Not applicable - Go to question 99

97. Date assessed: ___ ___ ___ ___ — ___ ___ — ___ ___

98. Was disease detected?
   □ Yes
   □ No

99. Was the disease status assessed via karyotyping?
   □ Yes - Go to question 100
   □ No - Go to question 102
100. Date assessed: ___ ___ ___ ___ — ___ ___ — ___ ___  

101. Was disease detected?
   □ Yes
   □ No

102. Was the disease status assessed by radiological assessment? (e.g. PET, MRI, CT)
   □ Yes - Go to question 103
   □ No - Go to question 105
   □ Not applicable - Go to question 105

103. Date assessed: ___ ___ ___ ___ — ___ ___ — ___ ___  

104. Was disease detected?
   □ Yes
   □ No

105. Was the disease status assessed by clinical/hematologic assessment?
   □ Yes - Go to question 106
   □ No - Go to question 108

106. Date assessed: ___ ___ ___ ___ — ___ ___ — ___ ___  

107. Was disease detected?
   □ Yes
   □ No

**Post-HCT Therapy**

Report therapy given since the date of last report to prevent relapse or progressive disease. This may include maintenance and consolidation therapy. Do not report any therapy given for relapsed, persistent, or progressive disease.

108. Was therapy given since the date of the last report for reasons other than relapse, persistent, or progressive disease? (Include any maintenance and consolidation therapy.)
□ Yes - Go to question 109
□ No - Go to question 113

109. Specify therapy (check all that apply)
   □ Blinded randomized trial - Go to question 113
   □ Cellular therapy - Go to question 113
   □ Radiation - Go to question 113
   □ Systemic therapy - Go to question 110
   □ Other therapy - Go to question 112

110. Specify systemic therapy (check all that apply)
   □ Alemtuzumab (Campath)
   □ Azacytidine (Vidaza)
   □ Blinatumomab
   □ Bortezomib (Velcade)
   □ Bosutinib
   □ Carfilzomib
   □ Chemotherapy
   □ Dasatinib (Sprycel)
   □ Decitabine (Dacogen)
   □ Gemtuzumab (Mylotarg, anti-CD33)
   □ Gilteritinib
   □ Ibrutinib
   □ Imatinib mesylate (Gleevec)
   □ Ixazomib
   □ Lenalidomide (Revlimid)
   □ Lestaurtinib
   □ Midostaurin
   □ Nilotinib (AMN107, Tasigna)
   □ Nivolumab
   □ Pembrolizumab
   □ Pomalidomide
   □ Quizartinib
   □ Rituximab (Rituxan, MabThera)
   □ Sorafenib
CIBMTR Center Number: ___ ___ ___ ___ ___  CIBMTR Research ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ Sunitinib
☐ Thalidomide (Thalomid)
☐ Other systemic therapy- Go to question 111

111. Specify other systemic therapy: ____________________

112. Specify other therapy: ____________________________

Relapse or Progression Post-HCT

Report if the recipient has experienced a clinical/hematologic relapse or progression post-HCT. If the relapse or progression was detected in a previous reporting period indicate that and continue on. If the first clinical/hematologic relapse occurred since the date of last report, indicate the date it was first detected in this reporting period.

113. Did the recipient experience a clinical/hematologic relapse or progression post-HCT?
   ☐ Yes - Go to question 114
   ☐ No - Go to question 116

114. Was the date of the first clinical/hematologic relapse or progression previously reported?
   ☐ Yes - Go to question 124 (only valid >day 100)
   ☐ No - Go to question 115

115. Date first seen: ___ ___ ___ ___ — ___ ___ — ___ ___
     YYYY                  MM      DD

Intervention for relapsed disease, persistent disease, or progressive disease

116. Was intervention given for relapsed, persistent or progressive disease since the date of last report?
   ☐ Yes - Go to question 117
   ☐ No - Go to question 124

117. Specify reason for which intervention was given:
   ☐ Persistent disease
   ☐ Relapsed / progressive disease
118. Specify the method(s) of detection for which intervention was given (check all that apply)
   - Clinical/hematologic
   - Cytogenetic
   - Disease specific molecular marker
   - Flow cytometry
   - Radiological (e.g. PET, MRI, CT)

119. Date intervention started: ___ ___ ___ ___ — ___ ___ — ___ ___
     YYYY MM DD

120. Specify therapy (check all that apply)
   - Blinded randomized trial - Go to question 124
   - Cellular therapy - Go to question 124
   - Radiation - Go to question 124
   - Systemic therapy - Go to question 121
   - Other therapy - Go to question 123

121. Specify systemic therapy (check all that apply)
   - Alemtuzumab (Campath)
   - Azacytidine (Vidaza)
   - Blinatumomab
   - Bortezomib (Velcade)
   - Bosutinib
   - Carfilzomib
   - Chemotherapy
   - Dasatinib (Sprycel)
   - Decitabine (Dacogen)
   - Gemtuzumab (Mylotarg, anti-CD33)
   - Gilteritinib
   - Ibrutinib
   - Imatinib mesylate (Gleevec)
   - Ixazomib
   - Lenalidomide (Revlimid)
   - Lestaurtinib
   - Midostaurin
122. Specify other systemic therapy: ____________________

123. Specify other therapy: ______________________________

Current Disease Status

124. What is the current disease status?
   - Complete remission (CR) - Go to question 126
   - Not in complete remission - Go to question 125
   - Not evaluated - Go to First Name

125. Specify disease status if not in complete remission:
   - Disease detected
   - No disease detected but incomplete evaluation to establish CR

126. Date of most recent disease assessment
   - Known – Go to question 127
   - Unknown – Go to First Name

127. Date of most recent disease assessment: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY       MM       DD

First Name: _____________________________________________________________________________________

Last Name: _____________________________________________________________________________________