# Post-Transplant Essential Data

Registry Use Only

Sequence Number:

Date Received:

OMB No: 0915-0310
Expiration Date: 08/31/2025

**Public Burden** Statement: The purpose of this data collection system is to provide technical assistance and share expertise with health care organizations, health care providers and health care networks interested in implementing telehealth technology. The resource centers serve as focal points for advancing the effective use of telehealth technologies in their respective communities and regions. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0310 and it is valid until 08/31/2025. Public reporting burden for this collection of information is estimated to average 0.51 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.

CIBMTR Center Number: ___ ___ ___ ___ ___

CIBMTR Research ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Event date: ___ ___ ___ ___ - ___ ___ - ___ ___

YYYY MM DD

Visit

☐ 100 day

☐ 6 months

☐ 1 year

☐ 2 years

☐ >2 years,Specify: ___ ___

CIBMTR Center Number: ___ ___ ___ ___ ___ CIBMTR Research ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

**Report all findings SINCE DATE OF LAST REPORT unless otherwise specified.**

## Survival

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

___ ___ ___ ___ – ___ ___ – ___ ___
YYYY MM DD

2. Specify the recipient's survival status at the date of last contact

- ☐ Alive – **Answers to subsequent questions should reflect clinical status.**
- ☐ Dead - **Answers to subsequent questions should reflect clinical status between the date of last report and immediately prior to death. Complete the Recipient Death Data Form 2900**

## Subsequent Infusion

3. Did the recipient receive a subsequent infusion?

- ☐ Yes – **Also complete Indication for CIBMTR Data Reporting Form 2814**
- ☐ No

## Initial ANC Recovery

4. Was there evidence of initial hematopoietic recovery?

- ☐ Yes *(ANC ≥ 500/mm$^3$ achieved and sustained for 3 lab values)* – ***Go to question 5***
- ☐ No *(ANC ≥ 500/mm$^3$ was not achieved)* – ***Go to question 6***
- ☐ Not applicable *(ANC never dropped below 500/mm$^3$ at any time after the start of the preparative regimen)* – ***Go to question 6***
- ☐ Previously reported *(recipient's initial hematopoietic recovery was recorded on a previous report)* – ***Go to question 6***

5. Date ANC ≥ 500/mm$^3$ *(first of 3 lab values)*: ___ ___ ___ ___ – ___ ___ – ___ ___
YYYY MM DD

6. Did late graft failure occur?

- ☐ Yes
- ☐ No

CIBMTR Center Number: ___ ___ ___ ___ ___ CIBMTR Research ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

## Initial Platelet Recovery

**(Optional for Non-U.S. Centers)**

7. Was an initial platelet count ≥ 20 x $10^9$/L achieved?
   - ☐ Yes – ***Go to question 8***
   - ☐ No – ***Go to question 9***
   - ☐ Not applicable *(Platelet count never dropped below 20 x $10^9$/L)* – ***Go to question 9***
   - ☐ Previously reported *(≥ 20 x $10^9$/L was achieved and reported previously)* – ***Go to question 9***

8. Date platelets ≥ 20 x $10^9$/L: ___ ___ ___ ___ — ___ ___ — ___ ___
   YYYY MM DD

## Graft vs. Host Disease

**If an allogeneic donor was used for the recipient's infusion, report all graft-versus-host disease occurring in this reporting period. If an allogeneic donor was not used, continue to Liver Toxicity Prophylaxis, question 35.**

9. Did acute GVHD develop?
   - ☐ Yes– ***Go to question 10***
   - ☐ No – ***Go to question 11***
   - ☐ Unknown – ***Go to question 11***

10. Date of acute GVHD diagnosis: ___ ___ ___ ___ — ___ ___ — ___ ___ - ***Go to question 12***
    YYYY MM DD

11. Did acute GVHD persist?
    - ☐ Yes– ***Go to question 19***
    - ☐ No – ***Go to question 27***
    - ☐ Unknown – ***Go to question 27***

12. 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, and/or grossly bloody stool*
- ☐ Not applicable *(acute GVHD present but cannot be graded)*

**List the stage for each organ at diagnosis of acute GVHD:**

13. 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*

14. 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*

15. Upper intestinal tract
    - ☐ Stage 0 – *No persistent nausea or vomiting*
    - ☐ Stage 1 – *Persistent nausea or vomiting*

16. 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)*

17. Other site(s) involved with acute GVHD
    - ☐ Yes – ***Go to question 18***
    - ☐ No – ***Go to question 19***

    18. Specify other site(s): _____

## Specify the maximum overall grade and organ staging of acute GVHD

19. 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, and/or grossly bloody stool*
- ☐ Not applicable *(acute GVHD present but cannot be graded)*

20. First date of maximum overall grade of acute GVHD: ___ ___ ___ ___ - ___ ___ - ___ ___
YYYY MM DD

21. 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*

22. 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*

23. Upper intestinal tract

- ☐ Stage 0 – *No persistent nausea or vomiting*
- ☐ Stage 1 – *Persistent nausea or vomiting*

24. 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)*

25. Other site(s) involved with acute GVHD
    - ☐ Yes – ***Go to question 26***
    - ☐ No – ***Go to question 27***

26. Specify other site(s): _____

27. Did chronic GVHD develop?
    - ☐ Yes – ***Go to questions 28***
    - ☐ No - ***Go to question 29***
    - ☐ Unknown – ***Go to question 29***

28. Date of chronic GVHD diagnosis: ___ ___ ___ ___ — ___ ___ — ___ ___ – ***Go to questions 30***
    YYYY MM DD

29. Did chronic GVHD persist?
    - ☐ Yes – ***Go to questions 30***
    - ☐ No - ***Go to question 33***
    - ☐ Unknown – ***Go to question 33***

**Specify the maximum grade of chronic GVHD**

30. Maximum grade of chronic GVHD *(according to best clinical judgment)*
    - ☐ Mild – ***Go to question 31***
    - ☐ Moderate – ***Go to question 31***
    - ☐ Severe – ***Go to question 31***
    - ☐ Unknown **– *Go to question 32***

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

32. 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*

33. 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

34. Is the recipient still taking (non-steroid) immunosuppressive agents (including PUVA) for GVHD?

- ☐ Yes
- ☐ No
- ☐ Not applicable
- ☐ Unknown

## Liver Toxicity Prophylaxis

35. Was specific therapy used to prevent liver toxicity?

- ☐ Yes – ***Go to question 36***
- ☐ No – ***Go to question 38***

36. Specify therapy *(check all that apply)*

- ☐ Defibrotide ***– Go to question 38***
- ☐ Enoxaparin (Lovenox) – ***Go to question 38***
- ☐ Heparin – ***Go to question 38***
- ☐ N-acetylcysteine ***– Go to question 38***
- ☐ Tissue plasminogen activator (TPA) ***– Go to question 38***
- ☐ Ursodiol ***– Go to question 38***
- ☐ Other – ***Go to question 37***

37. Specify other therapy: _____

## Veno-occlusive disease (VOD) / Sinusoidal obstruction syndrome (SOS)

**Specify if the recipient developed VOD / SOS**

38. Did veno-occlusive disease (VOD) / sinusoidal obstruction syndrome (SOS) develop?

- ☐ Yes – ***Go to question 39***
- ☐ No – ***Go to question 40***

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

## Infection

**Copy and complete questions 40 – 41 to report more than one infection.**

40. Did the recipient develop COVID-19 (SARS-CoV-2)?

- ☐ Yes – ***Go to question 41***
- ☐ No – ***Go to question 42***

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

42. Was a vaccine for COVID-19 (SARS-CoV-2) received?

- ☐ Yes – ***Go to question 43***
- ☐ No – ***Go to question 47***
- ☐ Unknown – ***Go to question 47***

**Copy and complete questions 43-46 to report all vaccine doses received.**

43. Specify vaccine brand

- ☐ AstraZeneca – ***Go to question 45***
- ☐ Johnson & Johnson's / Janssen – ***Go to question 45***
- ☐ Moderna – ***Go to question 45***
- ☐ Novavax – ***Go to question 45***
- ☐ Pfizer-BioNTECH – ***Go to question 45***
- ☐ Other type – **Go to question 44**

44. Specify other type: _____

45. Select dose(s) received

- ☐ One dose *(without planned second dose)*
- ☐ First dose *(with planned second dose)*
- ☐ Second dose
- ☐ Third dose
- ☐ Booster dose

46. Date received: ___ ___ ___ ___ — ___ ___ — ___ ___ □Date estimated
YYYY MM DD

**Copy and complete questions 43-46 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 the infusion was performed. Do not include relapse, progression or transformation of the same disease subtype.**

47. Did a new malignancy, myelodysplastic, myeloproliferative, or lymphoproliferative disease / disorder occur that is different from the disease / disorder for which the infusion was performed? *(include clonal cytogenetic abnormalities, and post-transplant lymphoproliferative disorders)*

- ☐ Yes **- Also complete Subsequent Neoplasms Form 3500**
- ☐ No
- ☐ Previously reported

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

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

48. Were chimerism studies performed?

- ☐ Yes – ***Go to question 49***
- ☐ No – ***Go to question 66***

49. Was documentation submitted to the CIBMTR? *(e.g. chimerism laboratory reports)* (CIBMTR recommends attaching the chimerism laboratory report)

- ☐ Yes
- ☐ No

50. 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.**

**Copy and complete questions 51–65 for multiple chimerism studies.**

51. Global Registration Identifiers for Donors (GRID): __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

52. NMDP cord blood unit ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

53. Registry donor ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

54. Non-NMDP cord blood unit ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

55. Donor date of birth:___ ___ ___ ___ — ___ ___ — ___ ___ **– OR –** Donor age: ___ ___
YYYY MM DD

☐ Months

☐ Years

56. Donor sex

☐ Male

☐ Female

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

58. Method

☐ Karyotyping for XX/XY– ***Go to question 60***

☐ Fluorescent in situ hybridization (FISH) for XX/XY – ***Go to question 60***

☐ Restriction fragment-length polymorphisms (RFLP) – ***Go to question 60***

☐ VNTR or STR, micro or mini satellite *(also include AFLP)* – ***Go to question 60***

☐ Single nucleotide polymorphisms (SNPs) *(includes quantitative PCR, real-time PCR, sequencing, other)* – ***Go to question 60***

☐ Other – ***Go to question 59***

59. Specify: _____

60. Cell source

☐ Bone marrow

☐ Peripheral blood

61. Cell type

☐ Unsorted / whole – ***Go to question 63***

☐ Red blood cells – ***Go to question 65***

☐ Hematopoietic progenitor cells *(e.g. CD34+ cells)* – ***Go to question 65***

☐ Total mononuclear cells *(e.g. lymphocytes & monocytes)* – ***Go to question 65***

☐ T-cells *(includes CD3+, CD4+, and/or CD8+)* – ***Go to question 65***

☐ B-cells *(includes CD19+ or CD20+)* – ***Go to question 65***

☐ Granulocytes *(includes CD33+ myeloid cells)* – ***Go to question 65***

☐ NK cells *(e.g. CD56+)* – ***Go to question 65***

☐ Other – ***Go to question 62***

62. Specify: _____

63. Total cells examined: ___ ___ ___ ___ ___ ___

64. Number of donor cells: ___ ___ ___ ___***- Go to question 66***

65. Percent donor cells: ___ ___ ___ %

**Copy and complete questions 51–65 for multiple chimerism studies.**

## Disease Assessment at the Time of Best Response to Infusion

66. Compared to the disease status prior to the preparative regimen, what was the best response to infusion? *(Include response to any therapy given for post-infusion 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 89***

☐ Complete remission (CR) - ***Go to question 68***

☐ Not in complete remission - ***Go to question 67***

☐ Not evaluated - ***Go to question 89***

67. Specify disease status if not in complete remission:

☐ Disease detected - ***Go to question 70***

☐ No disease detected but incomplete evaluation to establish CR - ***Go to question 70***

68. Was the date of best response previously reported?

☐ Yes - ***Go to question 89***

☐ No - ***Go to question 69***

69. Date assessed: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

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

70. Was the disease status assessed by molecular testing? *(e.g. PCR)*

☐ Yes - ***Go to questions 71***

☐ No - ***Go to question 73***

☐ Not applicable - ***Go to question 73***

71. Date assessed: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

72. Was disease detected?

☐ Yes

☐ No

73. Was the disease status assessed via flow cytometry?

☐ Yes - ***Go to question 74***

☐ No - ***Go to question 76***

☐ Not applicable - ***Go to question 76***

74. Date assessed: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

75. Was disease detected?

☐ Yes

☐ No

76. Was the disease status assessed by cytogenetic testing? *(karyotyping or FISH)*

☐ Yes - ***Go to question 77***

☐ No - ***Go to question 83***

☐ Not applicable - ***Go to question 83***

77. Was the disease status assessed via FISH?

☐ Yes - ***Go to questions 78***

☐ No - ***Go to question 80***

☐ Not applicable - ***Go to question 80***

78. Date assessed: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

79. Was disease detected?

☐ Yes

☐ No

80. Was the disease status assessed via karyotyping?

☐ Yes - ***Go to question 81***

☐ No - ***Go to question 83***

☐ Not applicable - ***Go to question 83***

81. Date assessed: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

82. Was disease detected?

☐ Yes

☐ No

83. Was the disease status assessed by radiological assessment? *(e.g. PET, MRI, CT)*

☐ Yes - ***Go to question 84***

☐ No - ***Go to question 86***

☐ Not applicable - ***Go to question 86***

84. Date assessed: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

85. Was disease detected?

☐ Yes

☐ No

86. Was the disease status assessed by clinical/hematologic assessment?

☐ Yes - ***Go to question 87***

☐ No - ***Go to question 89***

87. Date assessed: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

88. Was disease detected?

- ☐ Yes
- ☐ No

## Post-Infusion Therapy

**In questions 89-93, report therapy given 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.**

89. Was therapy given for reasons other than relapsed, persistent, or progressive disease? *(Include any maintenance and consolidation therapy.)*

- ☐ Yes - ***Go to question 90***
- ☐ No - ***Go to question 94***

90. Specify therapy *(check all that apply)*

- ☐ Blinded randomized trial - ***Go to question 98***
- ☐ Cellular therapy - ***Go to question 98***
- ☐ Radiation - ***Go to question 98***
- ☐ Systemic therapy - ***Go to question 91***
- ☐ Other therapy - ***Go to question 93***

91. Specify systemic therapy *(check all that apply)*

- ☐ Alemtuzumab (Campath) - ***Go to question 93***
- ☐ Azacytidine (Vidaza) - ***Go to question 93***
- ☐ Blinatumomab - ***Go to question 93***
- ☐ Bortezomib (Velcade) - ***Go to question 93***
- ☐ Bosutinib - ***Go to question 93***
- ☐ Brentuximab vendotin - ***Go to question 93***
- ☐ Carfilzomib - ***Go to question 93***
- ☐ Daratumumab (Darzalex) - ***Go to question 93***
- ☐ Dasatinib (Sprycel) - ***Go to question 93***
- ☐ Decitabine (Dacogen) - ***Go to question 93***
- ☐ Gemtuzumab (Mylotarg, anti-CD33) - ***Go to question 93***

- ☐ Gilteritinib - ***Go to question 93***
- ☐ Ibrutinib - ***Go to question 93***
- ☐ Imatinib mesylate (Gleevec) - ***Go to question 93***
- ☐ Ixazomib - ***Go to question 93***
- ☐ Lenalidomide (Revlimid) - ***Go to question 93***
- ☐ Lestaurtinib - ***Go to question 93***
- ☐ Midostaurin - ***Go to question 93***
- ☐ Nilotinib (AMN107, Tasigna) - ***Go to question 93***
- ☐ Nivolumab - ***Go to question 93***
- ☐ Pembrolizumab - ***Go to question 93***
- ☐ Pomalidomide - ***Go to question 93***
- ☐ Quizartinib - ***Go to question 93***
- ☐ Rituximab (Rituxan, MabThera) - ***Go to question 93***
- ☐ Sorafenib - ***Go to question 93***
- ☐ Sunitinib - ***Go to question 93***
- ☐ Thalidomide (Thalomid) - ***Go to question 93***
- ☐ Other systemic therapy- ***Go to question 92***

92. Specify other systemic therapy**: _____**

93. Specify other therapy***:*** **_____**

94. Did a fecal microbiota transplant (FMT) occur?
- ☐ Yes – ***Go to question 95***
- ☐ No – ***Go to question 98***

95. Date of FMT: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

96. Specify the indication for the FMT
- ☐ Graft versus host disease (GVHD) – ***Go to question 98***
- ☐ Clostridium difficile – ***Go to question 98***
- ☐ Other – ***Go to question 97***

97. Specify other indication: _____

CIBMTR Center Number: ___ ___ ___ ___ ___ CIBMTR Research ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

## Relapse or Progression Post-Infusion

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

98. Did the recipient experience a clinical/hematologic relapse or progression post-infusion?

- ☐ Yes - ***Go to question 99***
- ☐ No - ***Go to question 101***

99. Was the date of the first clinical/hematologic relapse or progression previously reported?

- ☐ Yes - ***Go to question 109*** *(only valid >day 100)*
- ☐ No - ***Go to question 100***

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

### Intervention for relapsed disease, persistent disease, or progressive disease

101. Was intervention given for relapsed, persistent or progressive disease?

- ☐ Yes - ***Go to question 102***
- ☐ No - ***Go to question 109***

102. Specify reason for which intervention was given

- ☐ Persistent disease
- ☐ Relapsed / progressive disease

103. 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)*

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

105. Specify therapy *(check all that apply)*

- ☐ Blinded randomized trial - ***Go to question 109***
- ☐ Cellular therapy - ***Go to question 109***
- ☐ Radiation - ***Go to question 109***
- ☐ Systemic therapy - ***Go to question 106***
- ☐ Other therapy - ***Go to question 108***

106. Specify systemic therapy *(check all that apply)*

- ☐ Alemtuzumab (Campath) - ***Go to question 108***
- ☐ Azacytidine (Vidaza) - ***Go to question 108***
- ☐ Blinatumomab - ***Go to question 108***
- ☐ Bortezomib (Velcade) - ***Go to question 108***
- ☐ Bosutinib - ***Go to question 108***
- ☐ Carfilzomib - ***Go to question 108***
- ☐ Chemotherapy - ***Go to question 108***
- ☐ Daratumumab (Darzalex) - ***Go to question 108***
- ☐ Dasatinib (Sprycel) - ***Go to question 108***
- ☐ Decitabine (Dacogen) - ***Go to question 108***
- ☐ Gemtuzumab (Mylotarg, anti-CD33) - ***Go to question 108***
- ☐ Gilteritinib - ***Go to question 108***
- ☐ Ibrutinib - ***Go to question 108***
- ☐ Imatinib mesylate (Gleevec) - ***Go to question 108***
- ☐ Ixazomib - ***Go to question 108***
- ☐ Lenalidomide (Revlimid) - ***Go to question 108***
- ☐ Lestaurtinib - ***Go to question 108***
- ☐ Midostaurin - ***Go to question 108***
- ☐ Nilotinib (AMN107, Tasigna) - ***Go to question 108***
- ☐ Nivolumab - ***Go to question 108***
- ☐ Pembrolizumab - ***Go to question 108***
- ☐ Pomalidomide - ***Go to question 108***
- ☐ Quizartinib - ***Go to question 108***
- ☐ Rituximab (Rituxan, MabThera) - ***Go to question 108***
- ☐ Sorafenib - ***Go to question 108***
- ☐ Sunitinib - ***Go to question 108***
- ☐ Thalidomide (Thalomid) - ***Go to question 108***

☐ Venetoclax - ***Go to question 108***

☐ Other systemic therapy- ***Go to question 107***

107. Specify other systemic therapy**: _____**

108. Specify other therapy***:*** _____

## Current Disease Status

109. What is the current disease status?

☐ Complete remission (CR) - ***Go to question 111***

☐ Not in complete remission - ***Go to question 110***

☐ Not evaluated – ***End of form***

110. Specify disease status if not in complete remission

☐ Disease detected

☐ No disease detected but incomplete evaluation to establish CR

111. Date of assessment of current disease status: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY MM DD