Indication for CIBMTR Data Reporting

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number: ___ ___ ___ ___ ___

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

DRAFT

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

Indication

1. Specify the indication for CIBMTR data reporting
   - ☐ Infusion **– *Go to question 3***
   - ☐ Marrow toxic injury **– *Go to question 2***
   - ☐ Non-cellular therapy *(e.g. study enrollment, chemotherapy, immunotherapy, etc.)* **– *Go to question 13***

2. Date of marrow toxic injury: __ __ __ __ - __ __ - __ __
   YYYY MM DD

Infusion

3. Does the product(s) infused contain CD34+ cells with the intent to establish / restore hematopoiesis?
   - ☐ Yes **– *Go to question 4*** *(e.g., HCT, gene therapy, or CD34+ Boost)*
   - ☐ No **– *Go to question 6*** *(e.g., cellular therapy)*

4. What was the primary indication for this infusion?
   - ☐ Graft failure – **Complete a Pre-TED Form 2400 for allogeneic HCT** – ***Go to question 6***
   - ☐ Poor graft function / insufficient donor chimerism – **Complete a Donor Cellular Infusion Form 2199** – ***Go to question 6***
   - ☐ Persistent / recurrent primary disease – **Complete a Pre-TED Form 2400** – ***Go to question 6***
   - ☐ Planned subsequent HCT, per protocol – **Complete a Pre-TED Form 2400** – ***Go to question 6***
   - ☐ New malignancy (including PTLD and EBV lymphoma) – **Complete a Pre-TED Form 2400** – ***Go to question 6***
   - ☐ Other – **Complete a Pre-TED Form 2400** – ***Go to question 5***

5. Specify other indication: _____

6. Are any of the products associated with this infusion genetically modified?
   - ☐ Yes **– *Go to question 7***
   - ☐ No – ***Go to question 8***

7. Was genetic modification performed to repair or correct a genetic defect?
   - ☐ Yes – **Complete a Pre-TED Form 2400**
   - ☐ No

8. Was the infusion a donor lymphocyte infusion (DLI)?
   - ☐ Yes – **Complete a Donor Lymphocyte Infusion Form 2199** – ***Go to question 9***

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☐ No – ***Go to question 10***

9. Number of DLIs in this reporting period: __ __

10. Specify donor

☐ Autologous **– *Go to question 12***

☐ Allogeneic, related **– *Go to question 11***

☐ Allogeneic, unrelated **– *Go to question 11***

11. Has this donor already provided cells for this recipient for a prior infusion?

☐ Yes

☐ No

12. Date of infusion: __ __ __ __ - __ __ - __ __
YYYY MM DD

Non-Cellular Therapy

13. Specify the disease / study for which non-cellular therapy was given *(check all that apply)*

☐ BMT CTN – ***Go to question 15***

☐ CMS Innovation Center's Cell and Gene Therapy (CGT) Access Model for Sickle Cell Disease (SCD) *(only applicable to gene therapy products Exagamglogene autotemcel (Casgevy ®) or Lovotibeglogene autotemcel (Lyfgenia ™))* – ***Go to question 15***

☐ WARRIOR-SCD: **W**hole-person **A**ssessment of **R**esponse and **R**isk after transformative therapies: **I**nvestigating **O**utcomes and **R**esilience in **S**ickle **C**ell **D**isease– ***Go to question 15***

☐ Other disease / study – ***Go to question 14***

14. Specify other disease / study: _____

15. Enrollment date: *(date of consent into study)* ___ ___ ___ ___ - ___ ___ - ___ ___
YYYY MM DD

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