Cellular Therapy Infusion

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number: ___ ___ ___ ___ ___

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

Event date: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

DRAFT

Copyright © 2026 The Medical College of Wisconsin, Inc and NMDP. All rights reserved.

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

Product Infusion

1. Specify the identifiers associated with this cell product *(check all that apply)*
   - ☐ Cell product ID **– *Go to question 2***
   - ☐ Batch number**– *Go to question 3***
   - ☐ Lot number **– *Go to question 4***

2. Cell product ID: _____

3. Batch number: _____

4. Lot number: _____

5. Date of this product infusion: ___ ___ ___ ___ — ___ ___ — ___ ___
   YYYY MM DD

6. Was the entire volume of product infused?
   - ☐ Yes – ***Go to question 9***
   - ☐ No– ***Go to question 7***

7. Specify what happened to the reserved portion *(check all that apply)*
   - ☐ Discarded – ***Go to question 9***
   - ☐ Cryopreserved for future use – ***Go to question 9***
   - ☐ Research – ***Go to question 9***
   - ☐ Training or Quality Control – ***Go to question 9***
   - ☐ Other fate – ***Go to question 8***

8. Specify other fate: _____

9. Specify the route of product infusion
   - ☐ Intravenous – ***Go to question 13***
   - ☐ Intramedullary – ***Go to question 13***
   - ☐ Intraperitoneal – ***Go to question 13***
   - ☐ Intra arterial - ***Go to question 13***
   - ☐ Intramuscular - ***Go to question 13***
   - ☐ Intrathecal / Intra-ventricular - ***Go to question 13***
   - ☐ Intraorgan - ***Go to question 11***
   - ☐ Locally in the tissue - ***Go to question 13***
   - ☐ Other route of infusion - ***Go to question 10***

Copyright © 2026 The Medical College of Wisconsin, Inc and NMDP. All rights reserved.

DRAFT

10. Specify other route of infusion: _____ - ***Go to question 13***

11. Specify the site of intraorgan administration of cells

- ☐ Bone - ***Go to question 13***
- ☐ Heart - ***Go to question 13***
- ☐ Liver - ***Go to question 13***
- ☐ Pancreas - ***Go to question 13***
- ☐ Kidney - ***Go to question 13***
- ☐ Brain - ***Go to question 13***
- ☐ Lung - ***Go to question 13***
- ☐ Other site - ***Go to question 12***

12. Specify other site: _____

Report the total number of cells (not cells per kilogram) contained in the product administered.

13. Total number of cells administered

- ☐ Known– ***Go to question 14***
- ☐ Unknown– ***Go to question 15***

14. Total number of cells administered: ___ ___ ___ ___ • ___ ___ x 10 ___ ___

15. Specify the cell type(s) administered *(check all that apply)*

Lymphocytes

- ☐ Lymphocytes (unselected) – ***Go to question 16***
- ☐ CD4+ lymphocytes – ***Go to question 17***
- ☐ CD8+ lymphocytes – ***Go to question 18***
- ☐ Regulatory T-cells (TREG) – ***Go to question 19***

Other Cells

- ☐ Mesenchymal stromal stem cells (MSCs) – ***Go to question 20***
- ☐ Unspecified mononuclear cells – ***Go to question 21***
- ☐ Other cell type – ***Go to question 22***

16. Total number of lymphocytes (unselected): ___ ___ ___ ___ • ___ ___ x 10 ___ ___

17. Total number of CD4+ lymphocytes: ___ ___ ___ ___ • ___ ___ x 10 ___ ___

18. Total number of CD8+ lymphocytes: ___ ___ ___ ___ • ___ ___ x 10 ___ ___

Copyright © 2026 The Medical College of Wisconsin, Inc and NMDP. All rights reserved.

DRAFT

19. Total number of TREG cells: ___ ___ ___ ___ ● ___ ___ x 10 ___ ___

20. Total number of MSCs: ___ ___ ___ ___ ● ___ ___ x 10 ___ ___

21. Total number of unspecified mononuclear cells: ___ ___ ___ ___ ● ___ ___ x 10 ___ ___

22. Specify other cell type:_____

23. Total number of other cells: ___ ___ ___ ___ ● ___ ___ x 10 ___ ___

Concomitant Therapy

24. Did the recipient receive concomitant therapy?

- ☐ Yes – ***Go to question 25***
- ☐ No – ***Go to End of Form***

Copy and complete questions 25 – 27 to report each concomitant therapy received.

25. Specify start date: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

26. Specify drug

- ☐ Atezolizumab (Tecentriq®) – ***Go to End of Form***
- ☐ Avelumab (Bavencio®) – ***Go to End of Form***
- ☐ Durvalumab – ***Go to End of Form***
- ☐ IL-2 – ***Go to End of Form***
- ☐ IL-15 – ***Go to End of Form***
- ☐ Ipilimumab (Yervoy®) – ***Go to End of Form***
- ☐ Lenalidomide (Revlimid®) – ***Go to End of Form***
- ☐ Nivolumab (Opdivo®) – ***Go to End of Form***
- ☐ Pembrolizumab (Keytruda) – ***Go to End of Form***
- ☐ Pomalidomide – ***Go to End of Form***
- ☐ Other - ***Go to question 27***

27. Specify other drug: _____

Copy and complete questions 25 – 27 to report each concomitant therapy received.

DRAFT

Copyright © 2026 The Medical College of Wisconsin, Inc and NMDP. All rights reserved.