Form 2143 R3.0: Multiple Sclerosis Post-HSCT Data

Center: CRID:

Key Fields

Sequence Number: _____

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

CIBMTR Center Number: _____

CIBMTR Recipient ID: _____

EBMT Center Identification Code (CIC): _____

Today's Date: __ __ __ __ - __ __- __ __

Date of HSCT for which this form is being completed: __ __ __ __ - __ __- __ __

HSCT type: (check all that apply)

- Autologous
- Allogeneic, unrelated
- Allogeneic, related
- Syngeneic (identical twin)

Product type: (check all that apply)

- Marrow
- PBSC
- Cord blood
- Other product

Specify: _____

Visit:

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

Specify: _____

Multiple Sclerosis Post-HSCT Data

Questions: 1 - 58

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

Disease Relapses or Progression of Disability Post-HSCT

2 Were there any relapses of multiple sclerosis (MS) since the date of the last report?

yes no

3 Specify the date of first relapse since the date of the last report: __ __ __ __ - __ __- __ __

4 Specify the number of relapses since the date of the last report: _____ number unknown

5 Did the recipient experience continuous progression of MS since the date of the last report?

yes no Unknown

6 Was a MRI scan of the brain performed since the date of the last report?

yes no Unknown

7 Date of most recent MRI: __ __ __ __ - __ __- __ __ Date unknown

8 Was disease relapse / progression detected on the MRI findings?

yes no

Specify which MRI findings indicated disease relapse / progression:

9 New gadolinium-enhancing lesions

yes no Unknown

10 Enlarging T2 lesions

yes no Unknown

11 Radiology report states worsening of MS associated findings

yes no Unknown

12 Were the Kurtzke Functional Systems Scores (FSS) assessed by a neurologist since the date of the last report?

yes no Unknown

13 Pyramidal score: _____ score unknown

14 Cerebellar score: _____ score unknown

15 Brainstem score: _____ score unknown

16 Sensory score: _____ score unknown

17 Bowel and bladder score: _____ score unknown

18 Visual score: _____ score unknown

19 Cerebral score: _____ score unknown

20 Other function score: _____ score unknown

21 Specify other function: _____

22 Specify the Kurtzke Expanded Disability Status Scale (EDSS): _____ EDSS unknown

23 Specify date of EDSS assessment: __ __ __ __ - __ __- __ __ Date unknown

Post-HSCT Treatment for Multiple Sclerosis

24 Did the recipient receive any treatment for MS since the date of the last report?

yes no Unknown

Specify the reason(s) for initiating post-HSCT therapy:

25 Continued therapy from pre-HSCT

yes no

26 Planned therapy per protocol

yes no

27 Disease relapse

yes no

28 Disease progression

yes no

29 Other reason

yes no

30 Specify other reason for initiating therapy: _____

31 What was the date the first therapy started? __ __ __ __ - __ __- __ __

Indicate all treatments for MS that the recipient received since the date of the last report:

32 Alemtuzumab (Campath)

yes no Unknown

33 Azathioprine (Azasan, Imuran)

yes no Unknown

34 Belimumab (LymphoStat-B)

yes no Unknown

35 Cladribine (2-CdA, Leustatin)

yes no Unknown

36 Corticosteroids (chronic use, not to treat acute relapse)

yes no Unknown

37 Corticosteroids (to treat acute relapse)

yes no Unknown

38 Cyclophosphamide (CTX, Cytoxan, Neosar)

yes no Unknown

39 Daclizumab (Zenapax, anti-CD25)

yes no Unknown

40 Fingolimod (FTY720)

yes no Unknown

41 Fumarate (oral) (BG00012)

yes no Unknown

42 Glatiramer acetate (Copaxone) [previously copolymer-1]

yes no Unknown

43 Immune globulin (IVIG, Gamimune, Gammagard)

yes no Unknown

44 Interferon beta-1a (Avonex, Rebif)

yes no Unknown

45 Interferon beta-1b (Betaseron)

yes no Unknown

46 Laquinimod

yes no Unknown

47 Methotrexate (MTX, Folex)

yes no Unknown

48 Mitoxantrone (Novantrone)

yes no Unknown

49 Mycophenolate mofetil (MMF, Cellcept)

yes no Unknown

50 Natalizumab (Tysabri, Antegren)

yes no Unknown

51 Rituximab (anti-CD20, Rituxan, MabThera)

yes no Unknown

52 Sirolimus (Rapamune)

yes no Unknown

53 Tacrolimus (FK 506, Prograf)

yes no Unknown

54 Teriflunomide (oral) (HMR1726)

yes no Unknown

55 Blinded randomized trial agent

yes no Unknown

56 Specify trial agent: _____

57 Other treatment

yes no Unknown

58 Specify other treatment: _____

If the person completing this form is a Neurologist, check here and continue with the signature lines below.

First Name: _____ Last Name: _____

Phone number: _____ Fax number: _____

E-mail address: _____