

Extracorporeal Photopheresis (ECP) for the Management of Progressive Bronchiolitis
Obliterans Syndrome (BOS) in Medicare-Eligible Recipients of Lung Allografts

BASELINE THERAPY - Case Report Form (CRF)

Please include the following types of source documents:

1. Clinical Note or Medication Record Form

Source Document Type	Document Name	Submission Date
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Select Source Document Type

Attach Source Document: No file chosen

Baseline Therapy Date:

1. Check all immunosuppressive drugs that are currently being used by the participant:

- | | | | |
|---------------------------|--------------------------|--|--|
| <input type="radio"/> YES | <input type="radio"/> NO | Tacrolimus | |
| <input type="radio"/> YES | <input type="radio"/> NO | Prednisone | If yes, enter daily dose: <input type="text"/> mg (input range: 0-150) |
| <input type="radio"/> YES | <input type="radio"/> NO | Sirolimus (Rapamycin) | |
| <input type="radio"/> YES | <input type="radio"/> NO | Everolimus | |
| <input type="radio"/> YES | <input type="radio"/> NO | Azathioprine | |
| <input type="radio"/> YES | <input type="radio"/> NO | Cyclosporine A | |
| <input type="radio"/> YES | <input type="radio"/> NO | Methotrexate | |
| <input type="radio"/> YES | <input type="radio"/> NO | Macrolide Antibiotic, Azithromycin | |
| <input type="radio"/> YES | <input type="radio"/> NO | Mycophenolate Mofetil (Cellcept or Myfortic) | |
| <input type="radio"/> YES | <input type="radio"/> NO | Total Lymphoid Irradiation | |

2. Is the participant taking an anticoagulant drug? ☐ YES ☐ NO

If yes, list drugs:

Name anticoagulant 1:

Name anticoagulant 2:

Name anticoagulant 3:

3. Is the participant taking an anti-platelet drug? ☐ YES ☐ NO

If yes, list drugs:

Name anti-platelet 1:

Name anti-platelet 2:

Name anti-platelet 3:

4. Comments: