Centre intégré universitaire de santé et de services sociaux de l'Est-de-l'Île-de-Montréal
Québec

EVALUATION FORM FOR CAR-T ELIGIBILITY IN LYMPHOMA
MAISONNEUVE-ROSEMONT HOSPITAL

PATIENT IDENTIFICATION

Last name			
First name			
Date of birth (YYYY/MM/DD)			
Address			
Health insurance number			
Expiration date of the health insurance card (YYYY/MM)			
Phone number (1)		Phone number (2)	
Mother's last name		Mother's first name	
Father's last name		Father's first name	
Spouse's last name		Spouse's first name	

REFERRING PHYSICIAN IDENTIFICATION

Last name				
First name				
Name and address of the referring Institution				
Province	Quebec			
Phone number		extension	Fax	
Email				

REFERRING NURSE IDENTIFICATION

Last name			First name	
Phone number		Extension	Fax	
Email				

IDENTIFICATION OF A CONTACT PERSON AMONG THE ONCOLOGY TEAM IF NOT THE NURSE

Last name			First name	
Function				
Phone number		Extension	Fax	
Email				

<u>To ensure timely management, please send the following to</u>

cart.hmr.cemlt@ssss.gouv.qc.ca

1) A consultation request,

2) All four pages of the present evaluation form completed,

3) A summary of the relevant medical history including significant complications from previous therapies,

4) All biopsy reports related to lymphoma, including bone marrow aspirates and biopsies if applicable. If the CD19 status is unknown, please send a request for analysis to Dr. Tony Petrella at the pathology department of Maisonneuve-Rosemont hospital and send the specimen at:

Hôpital Maisonneuve-Rosemont
Pavillon Maisonneuve, 3e étage, aile B
Secrétariat Pathologie
5415 boul. de l'Assomption, Montréal, Qc, H1T 2M4
<u>Phone number</u> : 514-252-3400 extension 3498 <u>Fax</u>: 514-252-3538

5) A report from the oncology pharmacy describing the different lines of therapy, the dates as well as the doses,

6) Reports of the imaging (scan/PET-scan/MRI) performed at diagnosis and at each progression and/or relapse. Patient must bring a digital copy (CD) of imaging at his/her first visit at Maisonneuve-Rosemont Hospital,

7) The initial assessment of the oncology nurse if available.

ELIGIBILITY CRITERIA LIST FOR CAR-T IN LYMPHOMA
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☐ Yes ☐ No	Age ≥ 18 years old
☐ Yes ☐ No	Histology ☐ Diffuse large B-cell lymphoma NOS ☐ High grade B lymphoma with MYC rearrangement and BCL2 and/or BCL6 ☐ High grade lymphoma NOS ☐ Transformed follicular lymphoma ☐ T-cell/histiocyte-rich large B-cell lymphoma ☐ Primary mediastinal B-cell lymphoma ☐ Diffuse large B-cell lymphoma associated with chronic inflammation ☐ EBV-positive diffuse large B-cell lymphoma ☐ Primary cutaneous lymphoma - *leg type* Excluded histologies ☐ Primary cutaneous lymphomas ☐ Transformed chronic lymphocytic leukemia ☐ Transformed lymphoplasmocytic lymphoma ☐ Transformed marginal zone lymphoma ☐ Burkitt lymphoma
☐ Yes ☐ No ☐ Unknown	CD19 status If CD19 status is unknown, was a request for analysis forwarded to Maisonneuve-Rosemont hospital? ☐ Yes o Date of request of the analysis to Maisonneuve-Rosemont hospital: ☐ No o Please provide the place and the contact's name where the analysis was requested: o Date the analysis was requested:
☐ Yes ☐ No	Recurrent status ≥ 2 lines of systemic therapy
☐ Yes ☐ No	Past therapies ☐ T-cells based therapies (BiTE or other) : ☐ High dose chemotherapy followed by autologous stem cell transplantation o Conditioning regimen: o Date of infusion: ☐ Allogeneic stem cell transplantation o Conditioning regimen: o Date of infusion: o Please provide a detailed report of the transplantation, GVHD and its management ☐ Gene therapy (*regardless of the indication*) : ***Please note that any exposure to an anti-CD19 treatment is an exclusion criterion***
☐ Yes ☐ No	Ineligibility for high-dose chemotherapy followed by autologous stem cell transplant (please check): ☐ Chemo-refractory ☐ Significant comorbidities as defined by a stem cell transplant committee (please provide details like a comorbidity scale for example):

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☐ Yes ☐ No	Life expectancy ≥ 12 weeks
☐ Yes ☐ No	ECOG performance score 0 or 1
☐ Yes ☐ No	Rapid clinical progression compromising a window for CAR-T evaluation and apheresis.
☐ Yes ☐ No	Clearance creatinine ≥ 45 ml/min/1,73m2 (CKD-EPI formula)
☐ Yes ☐ No	Liver function: ALT ≤ 5 times upper limit of normal
☐ Yes ☐ No	Respiratory capacity ☐ Grade ≤ 1 dyspnea ☐ Ambiant air O_2 saturation > 91%
☐ Yes ☐ No	Cardiac capacity ☐ LVEF ≥ 45% (ultrasound or isotopic ventriculography) ☐ Cardiac lymphomatous disease ☐ Unstable angina or infarction within 6 months before the consultation ☐ Arrhythmia not controlled within 6 months before the consultation
☐ Yes ☐ No	Bone marrow / lymphocyte capacity ☐ Absolute neutrophil count > 1.0 x 10^9/L ☐ Absolute lymphocyte count > 0,1 x 10^9/L ☐ Absolute count of T-cells CD3+ > 150 /µL ☐ Platelet count > 50 x 10^9/L (without transfusion)
☐ Yes ☐ No	Neurological conditions ☐ Past or current central nervous system involvement by lymphoma (conditional approval) ☐ History of convulsion, ischemia, cerebral hemorrhage, dementia or cerebellar disease ☐ Active neurologic inflammatory or autoimmune disease *Example : Guillain-Barre or amyotrophic lateral sclerosis*
☐ Yes ☐ No	Active infection ☐ Past or active B hepatitis ☐ Past or active C hepatitis ☐ Bacterial, viral or fungal ☐ HIV
☐ Yes ☐ No	Primary immunodeficiency
☐ Yes ☐ No	Other neoplasia with an estimated 5-year life expectancy of ≤ 75% *Please provide the pathology report, staging, treatments received and response to them.*

Hereby, as referring physician, I certify that the above information are correct.

Signature: _____ Date: