Lymphoma Pharmaceutical Supplemental Form

Instructions: *The TCGA treatment forms (Pharmaceutical and Radiation) act as supplemental forms to the Follow-up form and are due at the time the Follow-up form is submitted to the BCR. However, if the patient has completed treatment or if the patient is deceased, these forms can be submitted to the BCR at the time the Enrollment form is submitted.*

Questions regarding this form should be directed to the Tissue Source Site's primary Clinical Outreach Contact at the BCR.

Please note the following definitions for the "Unknown" and "Not Evaluated" answer options on this form.

Unknown: This answer option should only be selected if the TSS does not know this information after all efforts to obtain the data have been exhausted. If this answer option is selected for a question that is part of the TCGA required data set, the TSS must complete a discrepancy note providing a reason why the answer is unknown.

Not Evaluated: This answer option should only be selected by the TSS if it is known that the information being requested cannot be obtained. This could be because the test in question was never performed on the patient or the TSS knows that the information requested was never disclosed.

Tissue Source Site (TSS): _____TSS Identifier: _____ TSS Unique Patient Identifier: _____

Completed By *(Interviewer Name on OpenClinica)*: _____Completed Date: _____

Supplemental Information

#	Data Element	Entry Alternatives	Working Instructions
1*	Has this TSS received permission from the NCI to provide time intervals as a substitute for requested dates on this form?	☐ Yes ☐ No	Please note that the time intervals must be recorded in place of dates where designated throughout this form if you have selected "yes" in the box. *Provided time intervals must begin with the date of initial pathologic diagnosis (i.e., biopsy or resection).* *Only provide Interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.*

Treatment Information

#	Data Element	Entry Alternatives	Working Instructions
2*	Was Patient Treated on a Clinical Trial?	☐ Yes ☐ No	Indicate whether the patient was treated as part of a clinical trial (research study). 2503808
3*	Hematopoietic Stem Cell Transplantation	☐ Yes ☐ No	Indicate if the patient had a hematopoiectic stem cell transplantation performed. 3090688
4	Donor Type of Stem Cell Transplantation Utilized	☐ Autologous ☐ Allogeneic (sibling or partial match relative) ☐ Allogeneic (unrelated donor)	If stem cell transplantation was performed, indicate the type of stem cell transplantation. 2730901
5	Date of Stem Cell Transplantation	___ ___ / ___ ___ / ___ ___ ___ ___ *Month* *Day* *Year*	Provide the date that stem cell transplantation was performed. 3366911(Month), 3366912 (Day), 3366913 (Year)
6	Number of Days from Date of Initial Pathologic Diagnosis to Date Stem Cell Transplantation	_____	Provide the number of days from the date the patient was initially diagnosed pathologically with the disease to the patient's date of start of stem cell transplantation. 3414613

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#	Data Element	Entry Alternatives	Working Instructions
A Separate Pharmaceutical Supplemental Form must be completed for each regimen. All drugs within the regimen should be documented on the respective form. If "Single Agent Therapy" is selected and multiple single agents were given outside of a regimen, all single agents may be entered on a single pharmaceutical form if the indication of regiment and the pharmaceutical type are the same for all single agents.			
7*	Indication Of Regimen	☐ Primary ☐ Progression (after completion of Primary Treatment)	Indicate the reason for the administration of a treatment regimen. 2793511
8*	Pharmaceutical Type	☐ Chemotherapy ☐ Immunotherapy ☐ Targeted Molecular Therapy ☐ Other (please specify)	Indicate the pharmaceutical type (classification) for the drug being given. 2793530
9	Other Pharmaceutical Type, specify	_____	If the pharmaceutical type is not listed above, specify the other pharmaceutical type (classification) for the drug being given. 2001762
10*	Pharmaceutical Regimen	☐ Single Agent Therapy (please specify individual drug administered on the next tab "Name of Individual Drug Administered") ☐ BACOP ☐ CAP-BOP ☐ CHOP-14 ☐ CHOP-21 ☐ CHOP + Bleomycin ☐ CHOP + Etoposide ☐ CHOP-14 + Rituximab ☐ CHOP-21 + Rituximab ☐ CNOP ☐ C-MOPP ☐ CVP ☐ F-MACHOP ☐ DA-EPOCH ☐ DA-EPOCH + Rituxumab ☐ High Dose Methotrexate w/Leucovorin ☐ ICE ☐ ICE + Rituxumab ☐ LNH-84 ☐ LNH-87 ☐ M-BACOP ☐ MACOP-B ☐ ProMace-CytaBOM ☐ ProMace-MOPP ☐ VACOP-B ☐Other Pharmaceutical Regimen (please specify)	Indicate the pharmaceutical regimen that was administered to the patient for malignant lymphoma. 3366758
11	Other Pharmaceutical Regimen	_____	If the pharmaceutical regimen is not listed above, specify the other pharmaceutical regimen that was administered to the patient. 3366930

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#	Data Element	Entry Alternatives	Working Instructions
Pharmaceutical Information			
12*	Name of Individual Drug Administered (Brand or Generic)	_____	Provide the name of the individual pharmaceutical agent (drug) used to treat the patient. A separate form should be used for each drug. 2975232 *If patient is treated on a clinical trial and the drug name is unknown due to a blinded study or proprietary information, please leave this field blank and answer the next question regarding drug classification.*
13*	Number of Cycles	_____	Provide the total number of cycles of a specified drug that was administered during the current reporting period. 62590
14	Total Cumulative Dose	_____ mg	Provide the total cumulative dose in milligrams (mg) of the specified drug administered to the patient to include the entire cycle. 1515
Date of Therapy Start			
15*	Date of Therapy Start	__ __ / __ __ / __ __ __ __ *Month* *Day* *Year*	Provide the date that pharmaceutical therapy was started. 3103072 (Month), 3103070 (Day), 3103074 (Year)
16	Number of Days from Date of Initial Pathologic Diagnosis to Date Pharmaceutical Therapy Started	_____	Provide the number of days from the date the patient was initially diagnosed pathologically with the disease to the patient's date of start of pharmaceutical therapy. 3392465 *Only provide Interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.*
17*	Therapy Ongoing?	☐ Yes ☐ No	Indicate whether pharmaceutical therapy is ongoing. 3103479 *If therapy ongoing, date of therapy end should not be completed.*
Date of Therapy End			
18	Date of Therapy End	__ __ / __ __ / __ __ __ __ *Month* *Day* *Year*	Provide the date that pharmaceutical therapy was started. 3103080 (Month), 3103078 (Day), 31030782 (Year)
19	Number of Days from Date of Initial Pathologic Diagnosis to Date Pharmaceutical Therapy Ended	_____	Provide the number of days from the date the patient was initially diagnosed pathologically with the disease to the patient's date of end of pharmaceutical therapy. 3392470 *Only provide Interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.*

_____ _____ __ __/ __ __/ __ __ __ __

Principal Investigator or Designee Signature Print Name Date