CIC: ..... Hospital UPN: ..... Date of the first cell therapy infusion..... .... - .... - .....
(Do not write here the date of any HSCT) *yyyy* *mm* *dd*

Cell Therapy - MED - A

REGISTRATION - DAY 0

CENTRE IDENTIFICATION

EBMT Code (CIC): .....123..... ..... Hospital: ..... Unit: .Med. Klinik II

Contact person...Max Mustermann. e-mail: .....

Die Eingabe in ProMISe startet mit "Form about to be entered = 21 - Cell therapy: Day 0.
Danach kommt man in das Feld "Main indication for therapy (siehe Seite 2)

PATIENT DATA

Date of this Report: ..2021..- ....05... - ....03.....
yyyy *mm* *dd*

Datum, an dem die Daten aus der Patientenakte
- in die Datenbank übertragen werden oder
- auf das Papierformular übertragen werden

EBMT Registry Unique Identification Code (UIC) .....456.....
(if applicable)

Hospital Unique Patient Number or Code (UPN): .....445566.....
Compulsory, registrations will not be accepted without this item. ***All treatments performed in the same patient ~~must~~ be registered with the ~~same~~ patient identification number or code as this belongs to the patient and ~~not~~ to the treatment.***

Other type of patient identification codes: .....
(Optional: This item is to be used by the centre to register a patient code for internal use as necessary)

Initials: ...Er....._.....Mu..... (first name(s) _family name(s))

1 oder 2 Buchstaben pro Vor-/Nachname:
Erika Musterfrau: E M oder Er Mu

Date of Birth: ..1952.....- ...03.... - ....02.....
yyyy *mm* dd

Sex: ☐ Male ☑ Female
(at birth)

✓ = Beispieldaten

✓ = Bei Standardtherapie mit Yescarta bzw. Kymriah immer gleich

CIC: ..... Hospital UPN: ..... Date of the first cell therapy infusion..... .... - .... - .....
(Do not write here the date of any HSCT) *yyyy* *mm* *dd*

INDICATION FOR CELL THERAPY TREATMENT

SELECT ALL THAT APPLY

☑ **Treatment of a Primary disease, including Infections or Infection prevention**

Im Moment einzige zugelassene Indikation.
Weiter wieder auf Seite 1.

Date of initial diagnosis: .2020... - ...06..... - ..01...
yyyy mm dd

INDICATE THE PRIMARY DISEASE FOR WHICH THIS CELL THERAPY WAS GIVEN

☐ Primary Acute Leukaemia
- ☐ Acute myelogenous leukaemia (Page 11)
- ☐ Precursor lymphoid neoplasms (Page 13)
- ☐ Other Primary Acute Leukaemia (Page 14)

☐ Chronic Leukaemia
- ☐ Chronic Myeloid Leukaemia (CML) (Page 15)
- ☐ Chronic Lymphocytic Leukaemia (CLL) (Page 16)
- ☐ Prolymphocytic Leukaemia (PLL) (Page 17)

☑ Lymphoma (Page 18)
- ☐ Non Hodgkin
- ☐ Hodgkin's Disease

Weiter: Siehe vorletzte Seite!

☐ Myelodysplastic syndrome and/or myeloproliferative neoplasm (Page 18)
- ☐ MDS
- ☐ MDS/MPN
- ☐ Myeloproliferative neoplasm

☐ Myeloma /Plasma cell disorder (Page 23)

☐ Solid Tumour (Page 25)

☐ Bone marrow failure and/or graft failure (Page 24)

☐ Inherited disorders (Page 26)
- ☐ Primary immune deficiencies
- ☐ Metabolic disorders
- ☐ Other

☐ Histiocytic disorders (Page 27)

☐ Haemoglobinopathy (Page 24)

☐ Autoimmune disease
- ☐ Connective (Page 28)
- ☐ Vasculitis (Page 28)
- ☐ Arthritis (Page 29)
- ☐ Neurological (MS, etc) (Page 29)
- ☐ Haematological (Page 29)
- ☐ Bowel disorder (Page 30)
- ☐ Other (Diabetes, etc.) (Page 30)

☐ Infections (Page 32)

Other primary diseases
- ☐ Cardiovascular disease (Page 31)
- ☐ Muscoskeletal disorder (Page 31)
- ☐ Neurologic disorder (Page 31)
- ☐ Ocular disease, specify ……
- ☐ Pulmonary disease, specify ……

Complete and attach the relevant DISEASE CLASSIFICATION SHEET as per the page numbers indicated above, including the date of Cell therapy and disease status at Cell therapy, then continue to Clinical setting on the next page.

☐ **Treatment or prevention of complications derived or expected from a previous treatment including HSCT**

Indicate the date of the last HSCT for this patient ..... - ..... - ..... ☐ Not applicable
yyyy *mm* *dd*

Date of first cell infusion for this treatment ..... - ..... - .....
yyyy *mm* *dd*

☐ **Other indication, specify**:_____

Please, contact the Registry helpdesk before proceeding: registryhelpdesk@ebmt.org

CIC: ..... Hospital UPN: ..... Date of the first cell therapy infusion..... .... - .... - .....
(Do not write here the date of any HSCT) *yyyy* *mm* *dd*

THERAPY

Clinical setting: ☐ Clinical trial (CT)

Phase ☐ 1 ☐ 1/2 ☐ 2 ☐ 2/3 ☐ 3

Blind trial ☐ No ☐ Yes

Randomised trial ☐ No ☐ Yes

Eudract number…….. USA CT number…… UMIN CT number……
(Japan)

☐ Tick here if you want this registration hidden until ..... - ..... - .....
(indicate by which date the registration can be made available for research) yyyy mm dd

☑ Institutional guidelines / standard treatment
☐ Hospital exemption
☐ Compassionate use

Performance score of the patient at initiation of treatment

SYSTEM USED *(choose only one)*:

☑ Karnofsky or ☐ Lansky: Score: ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50 ☐ 60 ☐ 70 ☐ 80 ☑ 90 ☐ 100

☐ ECOG: Score: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Cell origin

☑ Autologous -> Go to CELL THERAPY INFUSION UNIT

☐ Allogeneic

This product is manufactured from:

☐ A known donor never used before to treat this patient -> Continue with DONOR section below
(eg. from a Donor registry or related)

☐ A donor that is already registered as part of a previous treatment -> Skip DONOR section and go to CELL THERAPY INFUSION UNIT

☐ An unknown donor with not available data -> Skip DONOR section and go to CELL THERAPY INFUSION UNIT
(eg. from a commercial product)

Donor

HLA match type

☐ HLA-identical sibling *(may include non-monozygotic twin)*
☐ Syngeneic *(monozygotic twin)*
☐ HLA-matched other relative
☐ HLA-mismatched relative: Degree of mismatch ☐ 1 HLA locus mismatch
☐ ≥ 2 HLA loci mismatch

Donor ID given by the centre .....

☐ Unrelated donor

ION code of the Donor Registry or Cord Blood Bank (*up to 4 characters*) ....

Name of donor registry or Cord Blood Bank ....

Donor centre name .....
(if applicable, optional)

Donor ID given by the Donor Registry or the Cord Blood Bank listed above .....

Patient ID given by the Donor Registry or the Cord Blood Bank listed above .....
(optional)

Donor information

Date of birth : .... - .... - .... **OR** Age at time of donation…… *years* …….. *months*
yyyy *mm* *dd* *(if date of birth not provided)*

Donor Sex ☐ Male ☐ Female
(at birth)

CIC: ..... Hospital UPN: ..... Date of the first cell therapy infusion..... .... - .... - .....
(Do not write here the date of any HSCT) *yyyy* *mm* *dd*

CELL THERAPY INFUSION UNIT(S)

Was there more than one cell infusion unit administered during this treatment
☑ No
☐ Yes: Number of different cell infusion units that form part of this treatment .....

Es gibt bei Yescarta und Kymriah üblicherweise nur eine Zellinfusion.

Cell Therapy Infusion Unit – Description and collection

If more than one cell infusion unit, replicate this section for each one of them

IDENTIFICATION

Name of the manufacturing facility ..Novartis.....Kite/Gilead..... ...

Name of the package *(if applicable)* .Kymriah..... Yescarta..... .....

Batch number *(if applicable)* ...XXX111XX.....

Identification of the Cell Infusion Unit given by the Centre ....1.....
If there is only one cell infusion unit write '1'.

Wenn nur eine Infusion gegeben wird, hier "1" eintragen.

TISSUE SOURCE *(check all that apply)*

☐ Bone Marrow
☐ Umbilical cord tissue
☐ Other, specify .....
☑ Peripheral Blood
☐ Adipose
☐ Umbilical cord Blood
☐ Tumour

Cell types *(check all that apply)*

☑ Unselected lymphocytes
☐ Mesenchymal
☐ NK cells
☐ Other, specify .....
☐ CD4+ lymphocytes
☐ Dendritic cells
☐ Mononuclear cells
☐ CD8+ lymphocytes
☐ CD34+

COLLECTION PROCEDURE *(check all that apply)*

Method
☐ Bone Marrow aspirate
☐ Byoptic sample
☑ Leukapheresis or lymphapheresis
☐ Other, specify……..

Date of the collection .20201 - .12. - ..02..
If more than one collection use the date of the first collecition
yyyy mm dd

Number of collections …1…

Mobilising agent(s) used

☑ No
☐ Yes, specify the agents used ……..……..
(G-CSF, Plerixafor, etc.)

CIC: ..... Hospital UPN: ..... Date of the first cell therapy infusion..... .... - .... - .....
(Do not write here the date of any HSCT) *yyyy* *mm* *dd*

Cell Therapy Infusion Unit – Manipulation

If more than one cell infusion unit, replicate this section for each one of them:

Identification of the Cell Infusion Unit given by the Centre .... CTIUCID

EX-VIVO MANIPULATION OF THE PRODUCTS CONTAINED IN THE CELL THERAPY INFUSION UNIT

☐ No -> Skip MANIPULATION section and go straight to CELL INFUSION PRODUCT FROZEN two pages below
☑ Yes -> Continue with MANIPULATION section below
☐ Unknown

Bei kommerziellen Produkten wie Yescarta und Kymriah würde es eigentlich genügen, wenn man "unknown" ankreuzt und den ganzen Abschnitt "Manipulation" leer lässt.

IF YES:

Manipulation laboratory

Onsite, by local cell processing facility	☑ No	☐ Yes
Offsite, by a non commercial facility	☑ No	☐ Yes
Offsite, by a commercial facility	☐ No	☑ Yes

Die EBMT wertet eine Zelltherapie aber nur als CAR-T-Zelltherapie, wenn im Feld "Transgene CAR" "Yes" eingetragen wurde.
Um zu diesem Feld zu gelangen, bitte diese Felder hier ausfüllen.

Gene manipulation

☐ No
☑ Yes: **TYPE**

Gene transfer ☐ No ☑ Yes:
- ☑ Retroviral vector, specify .unknown.....
- ☐ Lentiviral vector, specify .unknown.....
- ☐ Other vector specify .....

Yescarta = retroviraler Vektor
Kymriah = lentiviraler Vektor

Die beiden Felder verlangen einen Eintrag: Daher "unknown" o. ä. eintragen.

Number of gene transfer cycles .....

Wie oben erwähnt:
Das Feld "Transgene CAR"muss in ProMISe unbedingt mit "yes" ausgefüllt werden!

Transgene
- ☑ CAR, specify target .....CD19.....
- ☐ Suicide gene, specify .....
- ☐ TCR, specify target ..... / specify HLA element .....
- ☐ Other, specify .....

Gene editing ☐ No ☐ Yes: Manipulated gene
- ☐ CCR5
- ☐ Factor IX
- ☐ Factor VIII
- ☐ Other gene, specify .....

Other ☐ No ☐ Yes, specify .....

Recognition of a specific target / antigen

☐ No
☐ Yes: **TYPE** *(check all that apply)*

☐ Viral ☐ Adenovirus ☐ BK virus ☐ Cytomegalovirus (CMV)
☐ Epstein-Barr virus ☐ Human herpes virus 6 ☐ Human immunodeficiency virus (HIV)
☐ Other virus, specify .....

☐ Fungal ☐ Candida ☐ Aspergillus ☐ Fusarium ☐ Zygomycetes
☐ Other fungal, specify .....

☐ Tumour / cancer antigen, specify .....

☐ Other target, specify .....

Cell Therapy Infusion Unit – Manipulation (continued)

If more than one cell infusion unit, replicate this section for each one of them:

Identification of the Cell Infusion Unit given by the Centre .... CTIUCID

Selection

☐ No

☐ Yes: Positive ☐ No ☐ Yes

Negative ☐ No ☐ Yes

Kann alles leer gelassen werden.

Expansion

☐ No

☐ Yes: Number of days in culture……. or Expansion passage ……...

Expansion fold (ratio initial/final no. of cells)…….....

Induced differentiation

☐ No

☐ Yes

Was the cell infusion product frozen

☐ No

☑ Yes

CIC: ..... Hospital UPN: ..... Date of the first cell therapy infusion..... .... - .... - .....
(Do not write here the date of any HSCT) *yyyy* *mm* *dd*

THERAPY and CELL INFUSION(s)

Chronological number of cell therapy treatment for this patient . 1

Hier bitte nur Zelltherapien (z. B. DLI nach allogener Tx oder vorangegangene CAR-T-Therapie) zählen. Vorherige HSZT zählen nicht als cell therapy!

If number of cell therapy treatment >1:

Same package/product as for the previous cell therapy treatment? ☐ No ☐ Yes ☐ Not applicable

If >1, date of last cell therapy treatment before this one: ..... - .....-.....
yyyy *mm* *dd*

If >1, type of last cell therapy treatment before this one: ☐ Allo ☐ Auto

If >1 and Allograft, Was the same donor used for all prior and current cell therapy treatments?

☐ No ☐ Yes

If >1, was last cell therapy treatment performed at another institution?

☐ No ☐ Yes: CIC if known .....

Name of the institution .....

City .....

⇨ If >1, please submit a Cell Therapy Follow Up form before proceeding, **giving the date of the subsequent cell therapy as the date of last contact**. (This is so we can capture relapse data and other events between cell therapies).

Primary aim of the cell therapy treatment *(tick all that apply)*

verschiedene Zwecke möglich

*IF INDICATION IS THE TREATMENT OF A **PRIMARY DISEASE INCLUDING INFECTIOUS DISEASES***

☑ Main disease treatment
☑ Prevention of disease relapse or progression
☑ Disease relapse or progression
☐ Other, specify ....

*IF INDICATION IS THE **TREATMENT OR PREVENTION OF A COMPLICATIONS DERIVED FROM A PREVIOUS TRANSPLANT***

GvHD
☐ Unrelated to GvHD
☐ Prevention / prophylaxis of GvHD
☐ Treatment of GvHD

Graft function
☐ Unrelated to graft function
☐ Prevention of rejection / promotion of cell engraftment
☐ Graft enhancement
☐ Graft failure treatment

Immune reconstitution
☐ Unrelated to Immune reconstitution
☐ Immune reconstitution

Patient preparative treatment

☐ No ☑ Yes

Specification and dose of the preparative regimen

TOTAL PRESCRIBED CUMULATIVE DOSE* as per protocol: Include any systemic drugs (chemo, growth factors, antibodies, etc.)				
Name of drug (any given before day 0)	**DOSE**	**UNITS**		
...Fludarabine.....	75	☑ mg/m²	☐ mg/Kg	☐ AUC**
...Cyclophosphamide.....	750	☑ mg/m²	☐ mg/Kg	☐ AUC**
.....		☐ mg/m²	☐ mg/Kg	☐ AUC**
.....		☐ mg/m²	☐ mg/Kg	☐ AUC**
.....		☐ mg/m²	☐ mg/Kg	☐ AUC**
.....		☐ mg/m²	☐ mg/Kg	☐ AUC**
.....		☐ mg/m²	☐ mg/Kg	☐ AUC**

* Report the total prescribed cumulative dose as per protocol. **Multiply daily dose in mg/kg or mg/m² by the number of days**;
eg. for Busulfan given 4mg/kg daily for 4 days, total dose to report is 16mg/kg

** AUC = Area under the curve

Other type of treatment ☑ No ☐ Yes, specify ....

Konditionierung: Medikamente und Dosis können abweichen.
Bitte beachten: Dosis immer als *kumulative* Dosis angeben.
z. B. 25 mg/m2 Fludarabine an drei Tagen = 75 mg/m2

CELL INFUSION EPISODES

Were there more than one cell infusion episode during this treatment or procedure?

☑ No

☐ Yes: Number of cell infusion episodes during this procedure .....

Cell infusion episode

If more than one cell infusion episode, replicate this section for each one of them

Date of cell infusion episode ...2021/01/17.....

If more than one Unit was used, indicate the name of the Unit as described in the Cell Infusion Unit section

……. ***This item is mandatory if more than one unit was used***

Route of infusion *(check all that apply)*

☑ Systemic including Intravenous

☐ Local, specify: ☐ Intra-arterial ☐ Intramuscular

☐ Other route .....

Anzahl und Art der infundierten Zellen muss man nicht erfassen. Oft wird die Anzahl der Zellen vom Hersteller auch als Bereich (von-bis) angegeben. Das kann in ProMISe sowieso nicht erfasst werden.

Cells infused

Cell type		**Number of cells** *(Not adjusted for cell viability)*	**Units** *(tick one)* 10^6/kg	10^6
Lymphocytes CIEUNSLYMPH	UNSLYMUNIT	☐ Not evaluated	☐	☐
CD4+ lymphocytes		☐ Not evaluated	☐	☐
CD8+ lymphocytes CIECD4LYMP	CIECD8UNIT	☐ Not evaluated	☐	☐
CD3+ lymphocytes		☐ Not evaluated	☐	☐
Pathogen specific lymphocytes, specify…... CIESPTCNUM CIETCSPCFY	CSPTCUNIT	☐ Not evaluated	☐	☐
Tumour specific lymphocytes, specify……		☐ Not evaluated	☐	☐
Regulatory T-cells CIETCELREG	CITCELUNIT	☐ Not evaluated	☐	☐
Mesenchymal		☐ Not evaluated	☐	☐
Dendritic cells CIEDNDRCEL	CIDNDRUNIT	☐ Not evaluated	☐	☐
CD34+ cells		☐ Not evaluated	☐	☐
NK cells CIENKCELLS	CIENKUNIT	☐ Not evaluated	☐	☐
Mononuclear cells		☐ Not evaluated	☐	☐
Endothelial cell progenitor CIENDOTHEL	CIENDOUNIT	☐ Not evaluated	☐	☐
Other, specify		☐ Not evaluated	☐	☐

Did the treatment that includes this cell therapy episode also include other type of treatment?

☑ No ☐ Yes, specify……..

Was this other type of treatment given: ☐ No ☐ Yes ☐ Simultaneously to the cell therapy
☐ After the cell therapy episode was finished
☐ Unknown

Survival Status

☑ Alive ☐ Dead

Main Cause of Death *(check only one main cause)*:
☐ Relapse or Progression/Persistent disease
☐ Cell Therapy related: .....
☐ HSCT Related Cause
☐ Unknown
☐ Other: .....

Contributory Cause of Death *(check as many as appropriate)*:
☐ GVHD
☐ Cytokine release syndrome
☐ Interstitial pneumonitis
☐ Pulmonary toxicity
☐ Infection:
  ☐ bacterial
  ☐ viral
  ☐ fungal
  ☐ parasitic
  ☐ unknown
☐ Rejection/Poor graft function
☐ History of severe Veno occlusive disorder (VOD)
☐ Haemorrhage
☐ Cardiac toxicity
☐ Central nervous system (CNS) toxicity
☐ Gastrointestinal (GI) toxicity
☐ Skin toxicity
☐ Renal failure
☐ Multiple organ failure

☐ Other:.....

CIC: ..... Hospital UPN: ..... Date of the first cell therapy infusion..... .... - .... - .....
(Do not write here the date of any HSCT) *yyyy* *mm* *dd*

LYMPHOMAS
B-Cell and T-cell Non Hodgkin Lymphomas (NHL) (main disease code 3)

Disease

B-cell Neoplasms

- ☐ Splenic marginal zone lymphoma
- ☐ Extranodal marginal zone lymphoma of mucosa associated lymphoid tissue (MALT)
- ☐ Nodal marginal zone lymphoma
- ☐ Lymphoplasmacytic lymphoma (LPL)
  - ☐ Waldenstrom macroglobulinaemia (LPL with monoclonal IgM)
- ☐ Follicular lymphoma
- ☐ Primary cutaneous follicle centre lymphoma
- ☐ Mantle cell lymphoma
- ☑ Diffuse large B-cell lymphoma (DLBCL), (NOS)
  - ☐ T-cell/hystiocyte rich large B cell lymphoma
  - ☐ Primary DLBCL of the CNS
  - ☐ Primary cutaneous DLBCL, leg type
  - ☐ EBV positive DLBCL of the elderly
- ☐ DLBCL associated with chronic inflammation
- ☐ Lymphomatoid granulomatosis
- ☐ Primary mediastinal (thymic) large B-cell lymphoma
- ☐ Intravascular large B-cell lymphoma
- ☐ ALK positive large B-cell lymphoma
- ☐ Plasmablastic lymphoma
- ☐ Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease
- ☐ Primary effusion lymphoma (PEL)
- ☐ Burkitt lymphoma (BL)
- ☐ B-cell lymphoma, unclassifiable, with features intermediate between diffuse large B-cell lymphoma and Burkitt lymphoma (Intermediate DLCBL/BL)
- ☐ B-cell lymphoma, unclassifiable, with features intermediate between diffuse large B-cell lymphoma and classical Hodgkin lymphoma (Intermediate DLCBL/HD)
- ☐ Other B-cell, specify:_____

Mature T-cell & NK-cell Neoplasms

- ☐ T-cell large granular lymphocytic leukaemia
- ☐ Aggressive NK-cell leukaemia
- ☐ Systemic EBV positive T-cell lymphoproliferative disease of childhood
- ☐ Hydroa vacciniforme-like lymphoma
- ☐ Adult T-cell leukaemia/lymphoma
- ☐ Extranodal NK/T-cell lymphoma, nasal type
- ☐ Enteropathy-associated T-cell lymphoma
- ☐ Hepatosplenic T-cell lymphoma
- ☐ Subcutaneous panniculitis-like T-cell lymphoma
- ☐ Mycosis fungoides (MF)
- ☐ Sézary syndrome
- ☐ Lymphomatoid papulosis
- ☐ Primary cutaneous anaplastic large cell lymphoma
- ☐ Primary cutaneous gamma-delta T-cell lymphoma
- ☐ Primary cutaneous CD8 positive aggressive epidermotropic cytotoxic T-cell lymphoma
- ☐ Primary cutaneous CD4 positive small/medium T-cell lymphoma
- ☐ Peripheral T-cell lymphoma, NOS (PTCL)
- ☐ Angioimmunoblastic T-cell lymphoma
- ☐ Anaplastic large-cell lymphoma (ALCL), ALK-positive
- ☐ Anaplastic large-cell lymphoma (ALCL), ALK-negative
- ☐ Other T-cell, specify:_____

FOR B-CELL LYMPHOMAS:

Transformed from another type of lymphoma before this cell therapy treatment

- ☑ No
- ☐ Yes

Weiter: Siehe letzte Seite

Hodgkin Lymphomas

Classification:

- ☐ Nodular lymphocyte predominant
- ☐ Classical predominant
- ☐ Other, specify:_____

CIC: ..... Hospital UPN: ..... Date of the first cell therapy infusion..... .... - .... - .....
(Do not write here the date of any HSCT) *yyyy* *mm* *dd*

LYMPHOMAS

Status at cell therapy

Date of this cell therapy: .....2021. ....01. - ....17.....
yyyy *mm* *dd*

Number of prior lines of treatment ☐ 1 ☐ 2 ☑ 3 or more ☐ None ☐ unknown

Technique used for disease assessment:

CT scan done ☐ No ☑ Yes
PET ☐ Negative ☑ Positive ☐ Not evaluated

STATUS

- ☐ Never treated
- ☐ Complete remission (CR)
  - ☐ Unconfirmed (CRU*) ☐ Confirmed
  - *CRU – complete response with persistent scan abnormalities of unknown significance
- ☐ Partial response (PR) – (with or without a prior CR)
- ☐ Stable disease
- ☐ Untreated relapse (from a previous CR) / untreated progression (from a previous PR)
- ☑ Chemorefractory relapse or progression, including primary refractory disease
- ☐ Disease status unknown

Was this patient **refractory** to any line of chemotherapy before this Cellular Therapy? ☐ No ☑ Yes

Number of Complete remissions (CR, CRu) achieved by the patient prior to this Cellular Therapy: .....0.....
Count ~~all~~ CR including this one if applicable

0 enspricht Code 77 - None

Number of Partial remissions (PR) achieved by the patient prior to this Cellular Therapy: …2.....
Count ~~all~~ PR including this one if applicable

Weiter: Siehe Seite 3