

AUTOIMMUNE DISORDERS

DISEASE

Note: complete this form only if this diagnosis was the indication for the HCT/CT or if it was specifically requested. Consult the manual for further information.

Date of diagnosis: ____/____/____ (YYYY/MM/DD)

Classification:

Connective tissue:

Systemic sclerosis (SSc, scleroderma)

SSc type:

diffuse cutaneous

limited cutaneous

SSc sine scleroderma

Other SSc type; specify: _____

Systemic lupus erythematosus (SLE)

Mixed connective tissue disease (MCTD)

Polymyositis/Dermatomyositis (PM/DM)

Sjögren syndrome

Antiphospholipid syndrome

Other connective tissue disease; specify: _____

Vasculitis:

Granulomatosis with polyangiitis (GPA); *formerly Wegener granulomatosis*

Classical polyarteritis nodosa

Microscopic polyarteritis nodosa

Eosinophilic granulomatosis with polyangiitis (EGPA); *formerly Churg-Strauss*

Behçet syndrome

Takayasu arteritis

Other vasculitis; specify: _____

Arthritis:

Adult onset stills disease (AOSD)

Rheumatoid arthritis

Psoriatic arthritis/psoriasis

Juvenile idiopathic arthritis (JIA), systemic (Still's disease)

Juvenile idiopathic arthritis (JIA), articular

oligoarticular onset

polyarticular onset

Other juvenile idiopathic arthritis; specify: _____

Other arthritis; specify: _____

DISEASE continued

Classification:

Neurological diseases:

- Multiple sclerosis
- Myasthenia gravis
- Chronic inflammatory demyelinating polyneuropathy (CIDP)
- Neuromyelitis optica (NMO) or NMO spectrum disorders (NMOSD)
- Other autoimmune neurological disorder; specify: _____

Haematological diseases:

- Idiopathic thrombocytopenic purpura (ITP)
- Haemolytic anaemia
- Evans syndrome
- Autoimmune lymphoproliferative syndrome (primary diagnosis, not subsequent to transplant)
- Other haematological autoimmune disease; specify: _____

Inflammatory bowel diseases:

- Celiac disease
- Crohn's disease
- Ulcerative colitis
- Other autoimmune bowel disease; specify: _____

Other autoimmune diseases:

- Insulin-dependent diabetes mellitus (IDDM)
- Other autoimmune disease; specify: _____

PREVIOUS THERAPIES

Previous therapy lines before the HCT/CT:

- No (*this was the final question of the form*)
 Yes (*select an answer for each drug in the list below or specify other drug and complete the questions after the table*):
 Unknown

Adalimumab	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Alemtuzumab	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Anifrolumab	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Anti-CD20 antibodies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Azathioprine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Belimumab	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Corticosteroids	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Cyclophosphamide:	<input type="checkbox"/> Yes:	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
	total cumulative dose: __ mg		
Cyclosporine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Etanercept	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Filgotinib	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Fingolimod	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Infliximab	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Interferon	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Intravenous immunoglobulin (IVIG)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Methorexate	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Mitoxantrone	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Mycophenolate mofetil (MMF)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Natalizumab	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Nintedanib	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Non-steroidal anti-inflammatory (NSAID)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Ocrelizumab	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Tocilizumab	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Tofacitinib	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Upadacitinib	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Ustekinumab	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Vedolizumab	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Specify other drug*: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

*Please consult the **LIST OF CHEMOTHERAPY DRUGS/AGENTS AND REGIMENS** on the EBMT website for drugs/regimens names

Plasmapheresis: No Yes Unknown

Previous surgical procedures : No Yes Unknown

(*Crohn's disease only*)