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

INSTITUT UNIVERSITAIRE D'HÉMATO-ONCOLOGIE ET DE THÉRAPIE CELLULAIRE

CONSULTATION REQUEST FOR CAR-T CELL THERAPY FOR LYMPHOMA

Patient's last name and first name:			
Mother's maiden name:			
Health insurance number:	Expiry:	Date of birth (YYYY-MM-DD) :	
Address (n°, street):			
Postal code:	Telephone	Area code	Home number:
Area code Work number:	Ext.	Area code	Cell number:
Email address:			

Referring physician and establishment

Name of referring physician:	License number:	Name of establishment:	
Area code Phone number:	Extension	Area code Fax number:	
Email address:			
Copy of acceptance or refusal to: ☐ General practitioner ☐ Other physician			
Name and contact information, if applicable:			

Contacts in case of questions regarding the consultation request (if other than the referring physician)

Name of the contact:		Role:	
Area code Phone number:	Extension	Area code Fax number:	
Email address:			
Signature of referring physician :		Date:	

<u>In order to process the request in a timely manner, the following elements are required:</u>

1) Duly completed ***CONSULTATION REQUEST FOR CAR-T CELL THERAPY FOR LYMPHOMA.***

2) Duly completed ***ELIGIBILITY ASSESSMENT FORM FOR CAR-T (LYMPHOMA)***.

3) An overview of the patient's medical history including any significant complications relating to cancer treatments, including a hospitalization summary for stem cell transplantation if applicable.

4) All biopsy reports for lymphoma, lumbar puncture and bone marrow, including aspiration and flow cytometry as applicable.
<u>Please note that CD19 status is no longer an eligibility requirement for CAR-T.</u>

5) A report from the oncology pharmacy containing the different lines of treatment received, including dates and doses.

6) Imaging reports (scans/PET/MRI/cardiac exams) at the following timepoints: diagnosis, progression and/or relapse. *<u>The patient must bring a digital copy (CD) of these exams to the first visit.</u>*

7) The intake assessment by the oncology nurse navigator, if available.

8) **The above elements must be sent by email to: <u>cart.hmr.cemtl@ssss.gouv.qc.ca</u>**

*** At the time of the consultation request, we recommend that you initiate prophylaxis against the varicella-zoster virus in order to prevent an infection that could lead to a delay in procedures*

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INSTITUT UNIVERSITAIRE D'HÉMATO-ONCOLOGIE ET DE THÉRAPIE CELLULAIRE

ELIGIBILITY ASSESSMENT FORM FOR CAR-T (LYMPHOMA)

Nom et prénom de l'usager :			
Nom de la mère :			
N° d'assurance maladie :	Expiration :	Date de naissance (AAAA-MM-JJ) :	
Adresse (n°, rue) :			
Code postal :	Téléphone	Ind. rég. Résidence :	
Ind. rég. Travail :	Poste	Ind. rég. Cellulaire :	
Courriel :			

Inclusion Criteria: ALL ARE REQUIRED		
1) Age	≥ 18 years	☐ YES ☐ NO
2) Eligible histologies	☐ Diffuse large B-cell lymphoma NOS ☐ High-grade lymphoma with MYC and BCL2 and/or BCL6 rearrangement ☐ High grade lymphoma NOS ☐ Transformed follicular lymphoma ☐ T-cell/histiocyte rich B-cell lymphoma ☐ Primary mediastinal large B-cell lymphoma ☐ Diffuse large B-cell lymphoma associated with chronic inflammation ☐ EBV-positive diffuse large B-cell lymphoma ☐ Primary cutaneous lymphoma, leg type	☐ YES ☐ NO
3) Resistant or relapsed status	≥ 2 lines of systemic therapy	☐ YES ☐ NO
4) Ineligible for HDT-ASCT	Chemoresistant status OR prohibitive comorbidities	☐ YES ☐ NO
5) Life expectancy	≥ 12 weeks	☐ YES ☐ NO
6) ECOG performance status	0-1	☐ YES ☐ NO
7) Renal function	Creatinine clearance ≥ 45 ml/min/1.73 m^2 (CKD-EPI formula)	☐ YES ☐ NO
8) Hepatic function	ALT ≤ 5 times upper limit of normal	☐ YES ☐ NO
9) Respiratory capacity	Dyspnea grade ≤1 and ambient air oxygen saturation > 91%	☐ YES ☐ NO
10) Cardiac capacity	LVEF ≥ 45% (ultrasound or isotopic ventriculography)	☐ YES ☐ NO
11) Medullar capacity	Neutrophils > 1 x 10^9 /L	☐ YES ☐ NO
	Platelets without transfusion > 50 x 10^9 /L	☐ YES ☐ NO
12) Lymphocyte threshold	Lymphocyte count > 0.1 x 10^9 /L	☐ YES ☐ NO

Exclusion Criteria: NONE ARE PERMITTED		
1) Ineligible histologies	☐ Primary cutaneous lymphoma ☐ Transformed chronic lymphocytic leukemia ☐ Transformed lymphoplasmocytic lymphoma ☐ Transformed marginal zone lymphoma ☐ Burkitt lymphoma	☐ YES ☐ NO
2) Prior anti-CD19 treatment exposure		☐ YES ☐ NO
3) Gene therapy (any indication)		☐ YES ☐ NO
4) Primary immunodeficiency		☐ YES ☐ NO
5) Instable angina, infarctus or uncontrolled arrythmia within 6 months prior to consultation		☐ YES ☐ NO
6) Pregnant or breastfeeding		☐ YES ☐ NO
7) Active inflammatory or neurological auto-immune disease		☐ YES ☐ NO
8) Other neoplasia with 5 year life expectancy estimated at ≤ 75% : *Please provide the pathology report, staging, treatments and response*		☐ YES ☐ NO

Other Important Information	
1) Central nervous system lymphomatous infiltration (prior or current)	☐ YES ☐ NO
2) History of convulsions, ischemia, brain hemorrhage, cerebellar disease or dementia	☐ YES ☐ NO
3) History of hepatitis B, hepatitis C or HIV	☐ YES ☐ NO