

CAR-T REFERRAL FORM MANTLE 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.:	Cell number:
Email address:			

Referring physician and establishment			
Name of referring physician:		License number:	Name of establishment:
Area code:	Phone number:	Extension:	Fax number:
Email address:			
Copy of acceptance or refusal to: <input type="checkbox"/> General practitioner <input type="checkbox"/> 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:	Fax number:
Email address:			
Signature of referring physician:			Date:

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

- 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.
Please note that CD19 status is no longer an eligibility requirement for CAR-T.
- 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) of the last progression.** We will retrieve past imaging from Dossier Santé Québec (DSQ).
The patient must bring a digital copy (CD) of these exams to the first visit.
- 7) The intake assessment by the oncology nurse navigator, if available.
- 8) **The above elements must be sent by email to: cart.hmr.cemtl@ssss.gouv.qc.ca**

**** At the time of referral, 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**



ELIGIBILITY ASSESSMENT FORM FOR CAR-T IN MANTLE CELL LYMPHOMA

Nom et prénom de l'utilisateur :			
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 :	Cellulaire :
Courriel :			

Inclusion criteria: ALL ARE REQUIRED

1) Age	≥ 18 years	<input type="checkbox"/> YES <input type="checkbox"/> NO
2) Diagnosis	<input type="checkbox"/> Mantle cell lymphoma ** All morphological variants are covered These include: classic, pleomorphic and blastoid variants	<input type="checkbox"/> YES <input type="checkbox"/> NO
3) Past therapies	≥ 2 lines of systemic therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO
4) BTKi exposure	<input type="checkbox"/> Refractory or relapsing following BTKi ** A stable disease on BTKi is not eligible <input type="checkbox"/> BTKi intolerance requires documentation of a challenge at a reduced dose	<input type="checkbox"/> YES <input type="checkbox"/> NO
5) Prior lines of therapy	Exposure to at least one of the following <input type="checkbox"/> Anthracyclines <input type="checkbox"/> Bendamustine <input type="checkbox"/> High dose cytarabine	<input type="checkbox"/> YES <input type="checkbox"/> NO
5) Life expectancy	≥ 12 weeks	<input type="checkbox"/> YES <input type="checkbox"/> NO
6) Performance status	ECOG 0-1	<input type="checkbox"/> YES <input type="checkbox"/> NO
7) Renal function	Creatinine clearance ≥ 45 ml/min/1.73 m ² (CKD-EPI formula)	<input type="checkbox"/> YES <input type="checkbox"/> NO
8) Hepatic function	ALT ≤ 5 times upper limit of normal	<input type="checkbox"/> YES <input type="checkbox"/> NO
9) Respiratory capacity	Dyspnea grade ≤1 and ambient air oxygen saturation > 91%	<input type="checkbox"/> YES <input type="checkbox"/> NO
10) Cardiac capacity	LVEF ≥ 45% (ultrasound or isotopic ventriculography)	<input type="checkbox"/> YES <input type="checkbox"/> NO
11) Hematological capacity	Neutrophils > 1 x 10 ⁹ /L	<input type="checkbox"/> YES <input type="checkbox"/> NO
	Platelets without transfusion > 50 x 10 ⁹ /L	<input type="checkbox"/> YES <input type="checkbox"/> NO
12) Lymphocyte threshold	Lymphocyte count > 0.1 x 10 ⁹ /L	<input type="checkbox"/> YES <input type="checkbox"/> NO

Exclusion criteria: NONE ARE PERMITTED

1) Central nervous system lymphoma involvement (past or active, even if stable or controlled)	<input type="checkbox"/> YES <input type="checkbox"/> NO
2) Cardiac lymphoma involvement	<input type="checkbox"/> YES <input type="checkbox"/> NO
3) Prior exposure to a CD19 targeted therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO
4) Past allogeneic hematopoietic stem cell transplantation (irrespective of the GVHD status)	<input type="checkbox"/> YES <input type="checkbox"/> NO
5) Past exposure to any gene therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO
6) Non-malignant central nervous disease (CNS): seizure disorder, cerebrovascular ischemia or hemorrhage, dementia, cerebellar disease or any autoimmune disease with CNS involvement	<input type="checkbox"/> YES <input type="checkbox"/> NO
7) Primary immunodeficiency	<input type="checkbox"/> YES <input type="checkbox"/> NO
8) Pregnancy or breastfeeding	<input type="checkbox"/> YES <input type="checkbox"/> NO
9) Other neoplasia with 5 year life expectancy estimated ≤ 75% : <i>Please provide the pathology report, staging, treatments and response</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO

Other key informations

1) History unstable angina, myocardial infarction, cardiac angioplasty or stenting, significant arrhythmias or any clinically significant cardiac conditions in the last 3 months ** Case per case eligibility will be assessed	<input type="checkbox"/> YES <input type="checkbox"/> NO
2) Autoimmune disease requiring systemic immunosuppression ** Case per case eligibility will be assessed	<input type="checkbox"/> YES <input type="checkbox"/> NO
3) History of hepatitis B, hepatitis C or HIV (not an exclusion criteria)	<input type="checkbox"/> YES <input type="checkbox"/> NO
4) Prior exposure to a BiTE therapy not targeting CD19 (not an exclusion criteria)	<input type="checkbox"/> YES <input type="checkbox"/> NO