



CONSULTATION REQUEST CAR-T THERAPY IN LYMPHOMA (Dynamic Form)

Patient's last name and first name:			
Mother's maiden name:			
Health insurance number:	Exp :	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: <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	Area code 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 IN LYMPHOMA**.
- 2) Duly completed **ELIGIBILITY ASSESSMENT FORM FOR CAR-T IN LYMPHOMA**.
- 3) The latest medical evaluation note in hematology-oncology.
- 4) All lymphoma-related biopsy reports (including lumbar puncture or bone marrow analysis if 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 (dates and doses)
- 6) Imaging reports (scans/PET/MRI/cardiac exams) for the last 6 months.

The patient must bring a digital copy (CD) of these exams to the first visit.

- 7) Initial patient 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 the consultation request, we recommend that you initiate prophylaxis against the Varicella-Zoster virus to prevent an infection that could lead to a delay in procedures****



ELIGIBILITY ASSESSMENT CAR-T THERAPY IN LYMPHOMA

Patient's last name and first name:

Mother's maiden name:

Health insurance number:

Exp :

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:

Inclusion Criteria: ALL REQUIRED

1) Age	<input type="checkbox"/> ≥ 18 years old	<input type="checkbox"/> YES <input type="checkbox"/> NO
2) Accepted histologies	<input type="checkbox"/> Diffuse large B-cell lymphoma NOS <input type="checkbox"/> High-grade lymphoma NOS or with MYC and BCL2 rearrangement <input type="checkbox"/> Transformed follicular lymphoma <input type="checkbox"/> T cell/histiocyte-rich large B-cell lymphoma <input type="checkbox"/> Primary mediastinal large B-cell lymphoma <input type="checkbox"/> Diffuse large B-cell lymphoma associated with chronic inflammation or EBV <input type="checkbox"/> Primary cutaneous diffuse large B-cell lymphoma, leg type <input type="checkbox"/> Transformed marginal zone lymphoma** <input type="checkbox"/> Follicular grade 3B lymphoma** <input type="checkbox"/> Post-transplant lymphoproliferative disease** <input type="checkbox"/> Mantle cell lymphoma (any subtype)	<input type="checkbox"/> YES <input type="checkbox"/> NO
3) Refractory or recurrent status	<input type="checkbox"/> ≥ 2 lines of systemic therapy <input type="checkbox"/> For transformed lymphoma, failure to 1 line of therapy following a biopsy-proven transformation may be eligible if the previous therapy was delivered in an assumed transformed clinical setting** <input type="checkbox"/> For mantle cell lymphoma, refractoriness to BTKi (if intolerance, an unsuccessful trial at a reduced dose is required) and to the combination of an anti-CD20 and an anthracycline, cytarabine or bendamustine-based regimen	<input type="checkbox"/> YES <input type="checkbox"/> NO
4) Performance Status	0-1 AND life expectancy > 12 weeks	<input type="checkbox"/> YES <input type="checkbox"/> NO
5) Kidney Function	Creatinine clearance ≥ 45 mL/min/1.73 ^{m2} (CKD-EPI formula)	<input type="checkbox"/> YES <input type="checkbox"/> NO
6) Liver Function	ALT ≤ 5X normal	<input type="checkbox"/> YES <input type="checkbox"/> NO
7) Breathing Capacity	Dyspnea grade ≤ 1 and room air oxygen saturation > 91%	<input type="checkbox"/> YES <input type="checkbox"/> NO
8) Cardiac Capacity	LVEF ≥ 45% (ultrasound or isotope ventriculography)	<input type="checkbox"/> YES <input type="checkbox"/> NO
9) Bone marrow 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
10) Lymphocyte threshold	Lymphocyte count > 0.1 x 10 ⁹ /L	<input type="checkbox"/> YES <input type="checkbox"/> NO

Exclusion Criteria: NO PERMIT

1) Histologies excluded	<input type="checkbox"/> Primary cutaneous lymphoma <input type="checkbox"/> Chronic lymphocytic leukemia or transformed lymphoplasmacytic leukemia <input type="checkbox"/> Burkitt lymphoma	<input type="checkbox"/> YES <input type="checkbox"/> NO
2) Primary immunodeficiency OR gene therapy (any indication)		<input type="checkbox"/> YES <input type="checkbox"/> NO
3) Pregnancy or breastfeeding		<input type="checkbox"/> YES <input type="checkbox"/> NO
4) Active neurological inflammatory or autoimmune disease		<input type="checkbox"/> YES <input type="checkbox"/> NO
5) Another neoplasia with an estimated life expectancy ≤ 75% at 5 years: <i>Please provide the pathology report, staging, treatments received, and response to them</i>		<input type="checkbox"/> YES <input type="checkbox"/> NO

Other key information to be provided

1) Lymphoma with former or current secondary central nervous system infiltration**	<input type="checkbox"/> YES <input type="checkbox"/> NO
2) A history of hematopoietic stem cell transplantation without significant GVHD and without GVHD treatment may be considered**	<input type="checkbox"/> YES <input type="checkbox"/> NO
3) Previous exposure to anti-CD19 therapy may be considered **	<input type="checkbox"/> YES <input type="checkbox"/> NO
4) Unstable angina, infarction or uncontrolled arrhythmia within 3-6 months of consultation**	<input type="checkbox"/> YES <input type="checkbox"/> NO
5) History: seizure, ischemia, cerebral hemorrhage, cerebellar disease, or dementia	<input type="checkbox"/> YES <input type="checkbox"/> NO
6) History of hepatitis B, hepatitis C or HIV	<input type="checkbox"/> YES <input type="checkbox"/> NO

** Conditional on approval by waiver committee

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