

Patient Identification Number (Completed by the Coordinator for PROMACTA CARES)

PATIENT

Patient Information (Please Print)

Full Name: _____

Date of Birth: ____ / ____ / ____ Male Female Date of enrollment in PROMACTA CARES: ____ / ____ / ____

Diagnosis and date of diagnosis: _____

ICD-9 Code: _____ Is the patient still under your care? Yes No

If NO, please provide contact information for the new prescriber, if available:

Name: _____ Phone: _____

PRESCRIBER

Prescriber Information (Please Print)

First Name: _____ Last Name: _____

Phone: _____

PROMACTA Treatment Information

Start Date: ____ / ____ / ____

Last Dose Received: ____ mg QD QOD

Stop Date: ____ / ____ / ____

Platelet Count Upon Discontinuation: ____ (x 10⁹/L)

Reason for Discontinuation:

- Loss of response
- Lack of response
- Lost to follow-up
- Adverse event (specify): _____
- Death: Cause of Death: _____
Date Deceased: ____ / ____ / ____
- Other (specify): _____

Safety Information

Did any of the following Serious Adverse Events* occur with the discontinuation of PROMACTA?

After stopping PROMACTA, did the patient experience any bleeding event requiring hospitalization or medical intervention because the platelet count worsened below baseline levels? Yes No Under Investigation
Date of onset: ____ / ____ / ____

Liver abnormality Yes No Under Investigation
Date of onset: ____ / ____ / ____

Thrombosis or thromboembolism Yes No Under Investigation
Date of onset: ____ / ____ / ____

Bone marrow reticulin formation Yes No Under Investigation
Date of onset: ____ / ____ / ____

Bone marrow fibrosis Yes No Under Investigation
Date of onset: ____ / ____ / ____

* An adverse event is SERIOUS (SAE) when the patient outcome is: 1) Death – 2) Life threatening – 3) Hospitalization – initial or prolonged – 4) Significant disability/incapacity 5) Congenital anomaly/birth defect - 6) Other (important medical events)

Safety Information	Did any of the following Serious Adverse Events* occur with the discontinuation of PROMACTA?			
	Hematological malignancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Under Investigation
		If Yes, then describe: _____		
		<input type="checkbox"/> Progression of previously diagnosed disease	<input type="checkbox"/> New onset	Date of onset: ____/____/____

Post-Therapy Follow-up	Since the report of discontinuation, what is the status of the event(s)?					
	Event _____	<input type="checkbox"/> stabilized	<input type="checkbox"/> improved	<input type="checkbox"/> ongoing	<input type="checkbox"/> worsened	<input type="checkbox"/> resolved
	If stabilized/improved/resolved:	Date: ____/____/____				
	Event _____	<input type="checkbox"/> stabilized	<input type="checkbox"/> improved	<input type="checkbox"/> ongoing	<input type="checkbox"/> worsened	<input type="checkbox"/> resolved
	If stabilized/improved/resolved:	Date: ____/____/____				
	Event _____	<input type="checkbox"/> stabilized	<input type="checkbox"/> improved	<input type="checkbox"/> ongoing	<input type="checkbox"/> worsened	<input type="checkbox"/> resolved
	If stabilized/improved/resolved:	Date: ____/____/____				
	Event _____	<input type="checkbox"/> stabilized	<input type="checkbox"/> improved	<input type="checkbox"/> ongoing	<input type="checkbox"/> worsened	<input type="checkbox"/> resolved
If stabilized/improved/resolved:	Date: ____/____/____					

Reporter Information	Reporter Name/Title (Print)	Date of report:
	<input type="checkbox"/> PROMACTA CARES Specialist	____/____/____
	<input type="checkbox"/> Prescriber	(MM/DD/YY)
		_____ Signature

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Please fax this completed form to PROMACTA CARES at 1-866-765-0920.

You will receive enrollment confirmation via fax within 1 hour during 8:30AM-8:00PM M-F Eastern Standard Time.

For questions regarding PROMACTA CARES, call 1-877-9-PROMACTA (1-877-977-6622).