Patient Baseline Form

PROMACTA® CARES™
(eltrombopag)

PATIENT

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

#____________________

Patient Information (Please Print)

Full Name: ____________________

Initials: ________ Date of birth: _______ /_______ /_______ Gender: ❑ M ❑ F

Race: ❑ Caucasian ❑ Asian ❑ Hispanic ❑ African American ❑ Other ____________ ICD-9 Code: __________

Date of Enrollment in PROMACTA *CARES*: _______ /_______ /_______ Diagnosis and Date of Diagnosis ____________ _______ /_______ /_______

PATIENT BASELINE INFORMATION

Previous Treatment with PROMACTA Prior to Enrollment: ❑ Yes ❑ No If Yes, from (date): _______ /_______ /_______ to _______ /_______ /_______

Baseline Platelet Count Prior to Therapy: ____________ (x 10^9/L)

Splenectomy: ❑ Yes ❑ No If known, when (date): _______ /_______ /_______

Date ITP was First Diagnosed : _______ /_______ /_______ ❑ Unknown

Previous ITP Therapies:		Start Date	Stop Date
Corticosteroids:	❑ Yes ❑ No	____ /_____ /_____	_____ /_____ /_____
IVIg:	❑ Yes ❑ No	____ /_____ /_____	_____ /_____ /_____
Danazol:	❑ Yes ❑ No	____ /_____ /_____	_____ /_____ /_____
Rituximab	❑ Yes ❑ No	____ /_____ /_____	_____ /_____ /_____
Interferon alpha	❑ Yes ❑ No	____ /_____ /_____	_____ /_____ /_____
Azathioprine:	❑ Yes ❑ No	____ /_____ /_____	_____ /_____ /_____
Cyclophosphamide	❑ Yes ❑ No	____ /_____ /_____	_____ /_____ /_____
Other: ____________		____ /_____ /_____	_____ /_____ /_____
Other: ____________		____ /_____ /_____	_____ /_____ /_____
❑ Unknown			

Previous Bone Marrow Biopsy Results

❑ Yes ❑ No ❑ Report is attached
❑ Yes, not available ❑ Unknown

Previous History of Bone Marrow Abnormalities

❑ None ❑ Yes, select one or more of the following:

❑ AML ❑ CML ❑ Multiple Myeloma
❑ MDS ❑ NHL ❑ Amyloidosis
❑ ALL ❑ Hodgkins Disease ❑ Aplastic Anemia
❑ PNH ❑ Myeloproliferative Disorders ❑ Chronic Idiopathic Myelofibrosis

❑ Other, specify____________________

Previous Medical History

❑ History of thromboembolic events ❑ Yes ❑ No
❑ Risk Factors for thromboembolic events ❑ Yes ❑ No
❑ History of previous malignancy ❑ Yes ❑ No
❑ Current malignancy ❑ Yes ❑ No

❑ Other, specify____________________

Please Provide the Following Baseline Values:

Alanine aminotransferase (ALT) ________ Reference Range ____________
Aspartate aminotransferase (AST) ________ Reference Range ____________
Bilirubin ________ Reference Range ____________
Alkaline Phosphatase (Alk Phos) ________ Reference Range ____________

Previous History of Hepatic Abnormalities

❑ None ❑ Yes, select one or more of the following:

❑ Viral Hepatitis ❑ Autoimmune Hepatitis
❑ Alcoholic Liver Disease ❑ Gallbladder Disease
❑ Hepatic Cirrhosis

❑ Other, specify____________________

Current ITP Therapies

❑ No ❑ Yes, select one or more of the following:

❑ Corticosteroids ❑ IVIg ❑ Azathioprine
❑ Rituximab ❑ Interferon alpha
❑ Cyclophosphamide ❑ Danazol

❑ Other, specify____________________

REPORTER INFORMATION

	Reporter Name (Please Print)	PROMACTA Program ID # (found on enrollment confirmation fax)	Date of Report _______ /_______ /_______
❑ PROMACTA *CARES* Specialist			
❑ Healthcare Provider			Signature

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).

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