

AMGEN® Nplate® NEXUS Patient Baseline Data Form

1. Patient Information

Full Name _____(First) _____(Middle) _____(Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<u>Race</u> <input type="checkbox"/> Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> African American <input type="checkbox"/> Other: _____	Upon Initiation of Nplate® therapy is this patient:: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient If inpatient, referring physician _____ Telephone Number _____
Nplate® NEXUS Patient ID#: _____	Diagnosis: <input type="checkbox"/> ITP <input type="checkbox"/> MDS <input type="checkbox"/> Chemotherapy-induced thrombocytopenia <input type="checkbox"/> Other (please specify) _____	Date of Birth: _____ (MM/DD/YYYY)	

2. Patient ITP Information

Nplate® Therapy Start Date in NEXUS: _____ (MM/DD/YYYY)	Previous Treatment with Nplate® prior to enrollment: <input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, From: _____ To: _____ (MM/DD/YYYY) (MM/DD/YYYY)

Baseline Platelet Count Prior to Initiation of Nplate® Therapy : _____ (x 10⁹/L)

Has the Patient had Splenectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	If known, When: _____ (MM/DD/YYYY)
---------------------------------	--	---------------------------------------

Date ITP Was First Diagnosed _____/_____/_____ (MM/DD/YYYY) <input type="checkbox"/> Unknown	<u>Previous ITP Therapies</u>	<u>Current ITP Therapies</u>
	<i>(Please include all previous and current ITP therapies):</i>	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, select one or more of the following	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, select one or more of the following
	<input type="checkbox"/> Corticosteroids <input type="checkbox"/> IVIg <input type="checkbox"/> Danazol <input type="checkbox"/> Rituximab <input type="checkbox"/> Interferon alpha <input type="checkbox"/> Azathioprine <input type="checkbox"/> Cyclophosphamide <input type="checkbox"/> Cyclosporine <input type="checkbox"/> Vincristine <input type="checkbox"/> Anti-D <input type="checkbox"/> Eltrombopag Other: _____ Other: _____	<input type="checkbox"/> Corticosteroids <input type="checkbox"/> IVIg <input type="checkbox"/> Danazol <input type="checkbox"/> Rituximab <input type="checkbox"/> Interferon alpha <input type="checkbox"/> Azathioprine <input type="checkbox"/> Cyclophosphamide <input type="checkbox"/> Cyclosporine <input type="checkbox"/> Vincristine <input type="checkbox"/> Anti-D <input type="checkbox"/> Eltrombopag Other: _____ Other: _____

Previous Bone Marrow Biopsy Results Yes, report attached Yes, report not available No Unknown

Previous History of Bone Marrow Abnormalities Yes, select one or more of the following No Unknown

AML ALL CML Hodgkin's Disease Multiple Myeloma Essential Thrombocythemia
 MDS PNH NHL Polycythemia vera Aplastic Anemia Chronic Idiopathic Myelofibrosis
 CMML CLL Other: _____

3. Reporter Information

<input type="checkbox"/> Healthcare Professional / Reporter	Reporter Name (please print)	NEXUS Program ID #	Date of report: _____ (MM/DD/YYYY)
<input type="checkbox"/> Institution			
<input type="checkbox"/> Nplate® NEXUS Specialist			Signature _____

Please fax the completed form to The Nplate® NEXUS Program 1-877-675-2830
If you have questions, please contact the Nplate® NEXUS Program at 1-877-675-2831