



Nplate™ (romiplostim) NEXUS Program: Bone Marrow Reticulin / Bone Marrow Fibrosis

1. Patient Information			
Initials: _____	NEXUS Program ID: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: ___/___/___ <small>(MM/DD/YY)</small>
2. Nplate™ Administration Information			
Nplate™ Start Date: ___/___/___ <small>(MM/DD/YY)</small>	Is Nplate™ still being administered? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, what is the current dose? ___ µg/kg	
		If NO, enter date and dose of last administration ___/___/___ _____ µg/kg <small>(MM/DD/YY)</small>	
3. Safety Information			
Event: <input type="checkbox"/> Bone marrow reticulin <input type="checkbox"/> Bone marrow fibrosis			
Serious Event ¹ : <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Event: : ___/___/___ (MM/DD/YY)	
If serious, please document the reason for seriousness:			
<input type="checkbox"/> Hospitalization - initial or prolonged		<input type="checkbox"/> Death <input type="checkbox"/> Life-threatening	
<input type="checkbox"/> Persistent or significant disability/incapacity		<input type="checkbox"/> Congenital anomaly/birth defect	
		<input type="checkbox"/> Other (<i>important medical events</i>) _____	
Outcome of Event: <input type="checkbox"/> Resolved <input type="checkbox"/> Resolving/recovering <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Not resolved			
Peripheral Blood Smear Abnormal <input type="checkbox"/> Yes <input type="checkbox"/> No			
Bone Marrow Studies (Please note below, and attach reports)			
Bone marrow aspirate	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___ <small>(MM/DD/YY)</small>	Silver stain: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done
Bone marrow biopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___ <small>(MM/DD/YY)</small>	Trichrome stain: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done
Immunophenotype	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___ <small>(MM/DD/YY)</small>	Abnormalities: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, specify: _____
Cytogenetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___ <small>(MM/DD/YY)</small>	Abnormalities: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, specify: _____
What clinical features were present at the time of diagnosis? (check all that apply)	<input type="checkbox"/> Anemia <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Granulocytopenia <input type="checkbox"/> Hepatomegaly <input type="checkbox"/> Splenomegaly <input type="checkbox"/> Increased nucleated red blood cells (nRBCs) <input type="checkbox"/> Increased peripheral blast cells <input type="checkbox"/> Increased bruising/bleeding <input type="checkbox"/> Loss of efficacy to Nplate™ <input type="checkbox"/> Other (specify): _____		
Please quantify the degree of bone marrow reticulin/collagen using the Bauermeister scale (check only one):	<input type="checkbox"/> 0	No reticulin fibers demonstrable	
	<input type="checkbox"/> 1	Occasional fine individual fibers and foci of a fine fiber network	
	<input type="checkbox"/> 2	Fine fiber network throughout most of the section; no coarse fibers	
	<input type="checkbox"/> 3	Diffuse fiber network with scattered thick coarse fibers but no mature collagen (negative trichrome stain)	
	<input type="checkbox"/> 4	Diffuse, often coarse fiber network with areas of collagenization (positive trichrome stain)	
	<input type="checkbox"/> Other (please describe): _____		

¹ 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)



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3. Medical History

Were any of the following procedures performed **prior to** the onset of treatment with Nplate™? (e.g., is there baseline documentation of any of the following assessments?)

Bone marrow aspirate	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ (MM/DD/YY)	Silver stain:	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not done
Bone marrow biopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ (MM/DD/YY)	Trichrome stain:	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not done
Immunophenotype	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ (MM/DD/YY)	Abnormalities: <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, specify: _____		
Cytogenetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ (MM/DD/YY)	Abnormalities: <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, specify: _____		

Concomitant Medications:

Corticosteroids
 IVIg
 Danazol
 Rituximab
 Interferon alpha
 Azathioprine
 Cyclophosphamide
 Other (specify): _____
 None

4. Reporter Information

	Prescriber Name/Title (Print)	NEXUS Program ID # (found on enrollment confirmation fax)	Date of report: ____/____/____ (MM/DD/YY)
<input type="checkbox"/> NEXUS Specialist			_____ Signature
<input type="checkbox"/> Healthcare Provider			
<input type="checkbox"/> Institution			

**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**