

AUTOIMMUNE DISORDERS

If **VEXAS syndrome** concurrent with **MDS**, VEXAS syndrome should be reported as **non-indication diagnosis** using the Non-indication diagnosis form

DISEASE

Note: complete this form only if this diagnosis was the indication for the HCT/CT or if it was specifically requested. Consult the manual for further information.

Date of diagnosis: ____/____/____ (YYYY/MM/DD)

Classification:

Connective tissue:

- Systemic sclerosis (SSc, scleroderma)
 - SSc type:
 - diffuse cutaneous
 - limited cutaneous
 - SSc sine scleroderma
 - Other SSc type; specify: _____
- Systemic lupus erythematosus (SLE)
- Mixed connective tissue disease (MCTD)
- Polymyositis/Dermatomyositis (PM/DM)
- Sjögren syndrome
- Antiphospholipid syndrome
- Other connective tissue disease; specify: _____

Vasculitis:

- Granulomatosis with polyangiitis (GPA); *formerly Wegener granulomatosis*
- Classical polyarteritis nodosa
- Microscopic polyarteritis nodosa
- Eosinophilic granulomatosis with polyangiitis (EGPA); *formerly Churg-Strauss*
- Behçet syndrome
- Takayasu arteritis
- Other vasculitis; specify: _____

Arthritis:

- Adult onset stills disease (AOSD)
- Rheumatoid arthritis
- Psoriatic arthritis/psoriasis
- Juvenile idiopathic arthritis (JIA), systemic (Still's disease)
- Juvenile idiopathic arthritis (JIA), articular
 - oligoarticular onset
 - polyarticular onset
- Other juvenile idiopathic arthritis; specify: _____
- Other arthritis; specify: _____

DISEASE continued

Classification:

Neurological diseases:

- Multiple sclerosis
- Myasthenia gravis
- Chronic inflammatory demyelinating polyneuropathy (CIDP)
- Neuromyelitis optica (NMO) or NMO spectrum disorders (NMOSD)
- Other autoimmune neurological disorder; specify: _____

Haematological diseases:

- Idiopathic thrombocytopenic purpura (ITP)
- Haemolytic anaemia
- Evans syndrome
- Autoimmune lymphoproliferative syndrome (primary diagnosis, not subsequent to transplant)
- Other haematological autoimmune disease; specify: _____

Inflammatory bowel diseases:

- Celiac disease
- Crohn's disease
- Ulcerative colitis
- Other autoimmune bowel disease; specify: _____

Other Autoimmune/autoinflammatory diseases:

- Insulin-dependent diabetes mellitus (IDDM)
- VEXAS syndrome
- Other autoimmune disease; specify: _____

Only for VEXAS syndrome:

- Which form of VEXAS syndrome:** Without concurrent MDS
 With concurrent MDS (Complete the MDS diagnosis form and report VEXAS syndrome in Non-indication diagnosis form)
 Unknown

- How was the VEXAS diagnosis made:** Clinical diagnosis only
 Confirmed UBA1 mutation (e.g. Met41)
 Bone marrow features (e.g. vacuoles, dysplasia)
 Other method of VEXAS diagnosis, specify _____
 Unknown

PREVIOUS THERAPIES

Previous therapy lines before the HCT/CT:

- No (*this was the final question of the form*)
 Yes (*select an answer for each drug in the list below or specify other drug and complete the questions after the table*):
 Unknown

| | | | |
|---|-------------------------------|-----------------------------|----------------------------------|
| Adalimumab | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Alemtuzumab | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Anifrolumab | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Anti-CD20 antibodies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Azathioprine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Belimumab | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Corticosteroids | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Cyclophosphamide: | <input type="checkbox"/> Yes: | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| | total cumulative dose: __ mg | | |
| Cyclosporine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Etanercept | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Filgotinib | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Fingolimod | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Infliximab | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Interferon | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Intravenous immunoglobulin (IVIG) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Methorexate | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Mitoxantrone | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Mycophenolate mofetil (MMF) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Natalizumab | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Nintedanib | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Non-steroidal anti-inflammatory (NSAID) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Ocrelizumab | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Tocilizumab | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Tofacitinib | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Upadacitinib | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Ustekinumab | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Vedolizumab | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Specify other drug*: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

*Please consult the **LIST OF CHEMOTHERAPY DRUGS/AGENTS AND REGIMENS** on the EBMT website for drugs/regimens names

Plasmapheresis: No Yes Unknown

Previous surgical procedures : No Yes Unknown

(*Crohn's disease only*)