

June 30, 2006

FORMS PACKET

N0432 Phase II Trial of Docetaxel with Capecitabine and Bevacizumab as First-Line Chemotherapy for Patients with Metastatic Breast Cancer

Contents:

- Eligibility checklist (9/9/05)
- * Forms completion instructions
 - On-study form (11/4/04)
 - Baseline adverse events/symptoms (8/9/04)
 - Evaluation/treatment form (10/14/04)
 - Nadir/adverse event log (05/02/06)
 - Measurement form (10/14/04)
 - End of active treatment form (11/4/04)
 - Event monitoring form (7/20/2005)
 - Blood Specimen Submission Form (04/01/05)
 - Tumor Specimen Submission Form (04/01/05)
- ✓ Grade 4 or 5 non-AER reportable events/hospitalization form (6/1/06)
- ✓ MCLCT fax supply order form (11/1/04)

✓ designates revised/new forms

* Forms completion instructions are available on the NCCTG web site under “Generic Instructions for Forms Completion (MS Word).”

Rev. 8/17/04

Pathway: Protocol_Office_CCS/Boilerplates/Forms_packet_cover_sheet

Study reg. number _____

Eligibility Check - Answer questions below (yes/no). All requirements must be confirmed. All dates are to be M/D/Y.
Yes No

Required Characteristics

- ____ Yes ____ No Men or women with history of, or newly diagnosed, histologically or cytologically confirmed, invasive breast cancer with clinical evidence of metastases.
- ____ Yes ____ No Measurable disease defined as at least one measurable lesion per RECIST criteria. The RECIST criteria define measurable disease as at least one lesion whose longest diameter can be accurately measured as ≥ 2.0 cm by CT or MRI scans or as ≥ 1.0 cm by spiral CT scan. (See Section 11.0 for the RECIST criteria for measurable disease.) Clinical lesions will only be considered measurable when they are superficial (e.g., skin nodules, palpable lymph nodes). Lesions on chest x-ray are acceptable as measurable lesions when they are clearly defined and surrounded by aerated lung. However, CT is preferable.
- ____ Yes ____ No ≥ 18 years of age. Age = _____.
- ____ Yes ____ No No stage III or IV invasive, non-breast malignancies for ≥ 5 years.
- ____ Yes ____ No Prior adjuvant or neoadjuvant chemotherapy allowed, but no prior chemotherapy for metastatic disease.
- ____ Yes ____ No Previous antiestrogen hormone therapy is allowed, either in the adjuvant or metastatic disease.
- ____ Yes ____ No The following laboratory values obtained ≤ 14 days prior to registration. Earliest laboratory test date ____-____-____; latest laboratory test date ____-____-____. NOTE: These dates pertain to the following labs only.
 - ____ Yes ____ No • ANC $\geq 1500/\text{mm}^3$. ANC = _____.
 - ____ Yes ____ No • PLT $\geq 100,000/\text{mm}^3$. PLT = _____.
 - ____ Yes ____ No • HgB ≥ 8.0 g/dL. HgB = _____.
 - ____ Yes ____ No • Creatinine clearance ≥ 30 mL/min (calculated according to Cockcroft and Gault [see Appendix II]). Creatinine clearance = _____.

Note: In patients with moderate renal impairment (calculated creatinine clearance 30-50 mL/min) at baseline, a dose reduction to 80% of the capecitabine starting dose is recommended. This will be Dose Level -1 in Section 8 Dose Level Modification Table.

- ____ Yes ____ No • Urinalysis $< 1+$ protein. Patients discovered to have $\geq 1+$ proteinuria at baseline must undergo a 24-hour urine collection. This collection must be adequate, and must demonstrate < 1 g of protein/24 hr to allow participation in the study.
- ____ Yes ____ No • Total bilirubin $\leq \text{ULN}$. Total bilirubin = _____; ULN = _____.
- ____ Yes ____ No • AST **and** ALT **and** Alkaline Phosphatase must be within the range allowing for eligibility, as in the table below. In determining eligibility the more abnormal of the two values (AST or ALT) should be used.

	AST or ALT:			
ALK PHOS:	$\leq \text{ULN}$	$>1x$ but $\leq 1.5x$	$>1.5x$ but $\leq 5x$	$>5x \text{ ULN}$
$\leq \text{ULN}$	Eligible	Eligible	Eligible	Ineligible
$>1x$ but $\leq 2.5x$	Eligible	Eligible	Ineligible	Ineligible
$>2.5x$ but $\leq 5x$	Eligible	Ineligible	Ineligible	Ineligible
$>5x \text{ ULN}$	Ineligible	Ineligible	Ineligible	Ineligible

AST = _____; ULN = _____.
 ALT = _____; ULN = _____.
 Alkaline phosphatase = _____; ULN = _____.

- ____ Yes ____ No Life expectancy ≥ 3 months.
- ____ Yes ____ No ECOG performance status (PS) 0 or 1. PS = _____.
- ____ Yes ____ No If the patient's tumor is HER2-positive by either immunohistochemistry or by fluorescence in situ hybridization (FISH), the patient should have received trastuzumab-containing therapy, unless contraindicated, based on physician's discretion. If trastuzumab has been used for metastatic disease, it could have been given alone or with hormone therapy (but not with chemotherapy).

All responses in above section must be "Yes."

Study reg. number _____

Eligibility Check – (Contraindications continued)

Yes No

- ____ ____ Lack of physical integrity of the upper gastrointestinal tract, malabsorption syndrome, or the inability to tolerate oral medications.
- ____ ____ Major surgery ≤4 weeks prior to registration.
- ____ ____ Active infection.

All responses in above section must be “No.”

____ ____ Patient eligible.

Registration Check - Answer questions below (yes/no). All requirements must be confirmed. All dates are to be M/D/Y.

Yes No

- ____ ____ Consent form signed and dated. Date of consent ____ - ____ - ____.
- ____ ____ **Is this an USA institution?** (This question may be answered yes or no.)
 - ____ Yes → Complete authorization question below.
 - ____ No → Check “not applicable (**Non-USA institution only**)” and go to next question.
- ____ ____ Authorization for use and disclosure of protected health information signed and dated.
- ____ ____ Date of authorization ____ - ____ - ____ vs. not applicable (**Non-USA institution only**) ____.
- ____ ____ Treatment on this protocol must commence at the accruing membership under the supervision of an NCCTG member physician.
- ____ ____ Treatment cannot begin prior to registration and must begin ≤7 days after registration.
- ____ ____ Hematology group; Chemistry group; Creatinine Clearance, calculated; and Dipstick or standard urinalysis for proteinuria must be completed ≤14 days prior to registration (see Section 4.0). Earliest pretreatment tests/procedures date ____ - ____ - ____; latest pretreatment tests/procedures date ____ - ____ - ____.
- ____ ____ NOTE: The earliest pretreatment test date must be less than or equal to the earliest laboratory test date **and** the latest pretreatment test date must be greater than or equal to the latest laboratory test date.
- ____ ____ **Exceptions to the above dates:**
 - History and exam, wt, PS, BP; Height, Tumor measurement; and Chest x-ray or Chest CT to be done ≤21 days prior to registration (see Section 4.0). Earliest exception test date ____ - ____ - ____; latest exception test date ____ - ____ - ____.
 - Pregnancy test, for women of childbearing potential only, must be done ≤7 days prior to registration and (again, if necessary) ≤7 days prior to starting therapy (see Section 4.0). Date of pregnancy test prior to registration ____ - ____ - ____ vs. not done ____.
 - If pregnancy test not done, reason: _____.
- ____ ____ All required baseline symptoms must be documented and graded.
- ____ ____ Study drug availability checked.

All responses in above section must be “Yes.”

Study reg. number _____

Registration Check – (continued)

Yes No

At the time of registration/randomization, the following will also be recorded:

____ Patient has given permission to provide blood sample(s) to laboratories associated with NCCTG for future research testing.

____ Patient has given permission to provide tissue sample(s) to laboratories associated with NCCTG for future research testing.

____ Patient has given permission to store and use blood sample(s) for future research about cancer.

____ Patient has given permission to store and use blood sample(s) for future research to learn about, prevent, or treat other health problems.

____ Patient has given permission to store and use tissue sample(s) for future research about cancer.

____ Patient has given permission to store and use tissue sample(s) for future research to learn about, prevent, or treat other health problems.

____ Patient has given NCCTG permission to give their blood sample(s) to outside researchers.

____ Patient has given NCCTG permission to give their tissue sample(s) to outside researchers.

Responses in above section may be “Yes” or “No.”

____ Randomization/registration allowed.

Descriptive Factors

Neo-adjuvant or adjuvant chemotherapy

____ Yes

____ No

Prior anthracycline

____ Neoadjuvant

____ Adjuvant

____ None

Prior taxanes

____ Neoadjuvant

____ Adjuvant

____ None

HER2 method

____ Immunohistochemistry

____ FISH

____ Not done

Assigned Treatment

____ A) Docetaxel + Bevacizumab + Capecitabine

Person registering _____ Random. specialist _____
Signature initials

Physician _____
Signature M - D Y

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

ON-STUDY FORM

Protocol # N0432

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

DESCRIPTION OF PRIMARY DISEASE

Primary Tumor Site: Breast

Tumor Laterality (Check one)

- Cell Type: 1 Infiltrating ductal, 2 Infiltrating lobular, 3 Other, specify

- 1 Left, 2 Right, 3 Bilateral

Nottingham Grade 1-Well 2-Moderate 3-Poor 9-Unknown

CHRONOLOGY OF DIAGNOSES

Table with columns for DATES (m m d d y y y y) and METHOD of DX* (Primary, First local recurrence, First regional/distant recurrence)

* (1-None 2-Yes, biopsy 3-Yes, cytology 4-Yes, clinical)

REGIONAL/DISTANT METASTASES (Method of Dx*)

- Checkboxes for Nodal (excludes axillary), Nodal-axillary, Liver, Other, Skin, Abdominal, Bone, Brain, Lung, Chestwall

* (1-None 2-Yes, biopsy 3-Yes, cytology 4-Yes, clinical)

PREVIOUS BREAST SURGERY RELATED TO TUMOR (2-No, 1-Yes)

- Operative Procedure: Lumpectomy, Mastectomy, Sentinel node detection (Positive/Negative), Axillary lymph node dissection (ALND)

Number of positive nodes (include both sentinel node biopsy and ALND results)
Number of nodes examined (include both sentinel node biopsy and ALND results)

Other _____

Date (mm/dd/yyyy) grid for recording dates

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP
ON-STUDY FORM

Protocol # N0432

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

PREVIOUS RADIOTHERAPY (2-No, 1-Yes, describe below)

Site	Date (mm/dd/yyyy)					
	From			To		
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

PREVIOUS SYSTEMIC THERAPY FOR BREAST CANCER (2-No, 1-Yes, describe below)

Therapy	Date (mm/dd/yyyy)						Was Therapy:	
	From			To			1 <input type="checkbox"/> Adjuvant	2 <input type="checkbox"/> Metastatic
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	1 <input type="checkbox"/> Adjuvant	2 <input type="checkbox"/> Metastatic
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	1 <input type="checkbox"/> Adjuvant	2 <input type="checkbox"/> Metastatic
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	1 <input type="checkbox"/> Adjuvant	2 <input type="checkbox"/> Metastatic
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	1 <input type="checkbox"/> Adjuvant	2 <input type="checkbox"/> Metastatic
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	1 <input type="checkbox"/> Adjuvant	2 <input type="checkbox"/> Metastatic

Current Diabetes: (2-No, 1-Yes) How long? _____ months. Describe: _____

Current Symptoms: (2-No, 1-Yes) Specify _____

Any Previous Cancer: (2-No, 1-Yes) Site: _____ Date Diagnosis: _____ Treatment: _____

Other Current Chronic Diseases: (2-No, 1-Yes) Specify _____

Concurrent Medications: (2-No, 1-Yes) Specify _____

PREDOMINANT SITE OF DISEASE 1 Soft tissue 2 Osseous 3 Visceral

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

ON-STUDY FORM

Protocol # N0432

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

ESTROGEN/PROGESTERONE DATA

Most recent result prior to registration:

Estrogen (check one)

- 1 Positive
- 2 Negative
- 3 Unknown/no data

Date (mm-dd-yyyy)

--	--	--	--	--	--	--	--

Progesterone (check one)

- 1 Positive
- 2 Negative
- 3 Unknown/no data

--	--	--	--	--	--	--	--

Her2

Her2 Status/IHC (check one)

- 0 0
- 1 1+
- 2 2+
- 3 3+

Her2 Status/FISH (check one)

- 1 Amplified
- 2 Not amplified

R/G ratio

_____ . _____

% greater than or equal to 3 copies

_____ . _____

+17 (check one)

- 1 Yes
- 2 No

Her2 finding (check one)

- 1 Pos Her2
- 2 Neg Her2
- 3 Not done

HEIGHT

(CM):

--	--	--	--

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

BASELINE

ADVERSE EVENTS/SYMPTOMS

FORM

Protocol # N0432

Patient ID # _____ Initials: _____ L F M

Local ID # _____ Institution _____

BASELINE ADVERSE EVENTS/SYMPTOMS

Baseline # of Stools Per Day:

Required Baseline Adverse Events from Section 10.0 of Protocol		
Adverse Event/Symptom	MedDRA Code v. 6.0	Grade (CTCAE v. 3.0)
Cardiac ischemia/infarction	1 0 0 2 8 6 0 0	0 1 2 3 4
Fatigue (lethargy, malaise, asthenia)	1 0 0 1 6 2 5 6	0 1 2 3 4
Hair loss/alopecia (scalp or body)	1 0 0 0 1 7 6 0	0 1 2 ■ ■
Rash: hand-foot skin reaction	1 0 0 2 4 7 7 2	0 1 2 3 ■
Proteinuria	1 0 0 3 7 0 3 2	0 1 2 3 4
Neuropathy: motor	1 0 0 3 4 5 8 0	0 1 2 3 4
Neuropathy: sensory	1 0 0 3 4 6 2 0	0 1 2 3 4
Thrombosis/thrombus/embolism	1 0 0 4 3 6 0 7	0 ■ 2 3 4

NORTH CENTRAL CANCER TREATMENT GROUP

EVALUATION/TREATMENT FORM
ALL ITEMS MUST BE COMPLETED

Protocol # N0432

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

Amended Data: if yes, check box and **highlight** amended areas

Use one form per cycle, one column per agent.

Cycle: Is this: (check one) 1 Initial Treatment 2 Retreatment after PD (CR Patients only)

Actual Weight (kg): .
(used for this cycle, round to the nearest tenth)

ECOG Perf. Status (check one): 0 1 2 3 4
(used for this cycle)

Check One: Treatment (complete rest of form) Observation (CR patients only) → Day 1 of this observation cycle //

1 End of observation? (check if yes)

↓
Stop here

BSA(m²): .
(used for this cycle)

Was this cycle of treatment held? 1 Yes 2 No

Primary Reason

- 35 Hematologic
- 66 Hand-foot skin reaction
- 42 Diarrhea
- 44 Mucositis/stomatitis
- 99 Other (not per protocol) _____
- 97 Infection
- 45 Rash/desquamation
- 50 Hepatic
- 70 Neurologic

Agent Start Date this cycle (mm/dd/yyyy)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Were GCSFs given this cycle? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Agent	Docetaxel (TATER)	Capecitabine (CAPCIT)	Bevacizumab (AVASTN)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Dose Level day one this cycle (i.e. mg/m ²)				Was filgrastim given this cycle? (e.g. Neupogen) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Total Dose (mg) this cycle				1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Was DOSE LEVEL adjusted this cycle? (i.e. mg/m ²)	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no ↓	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no ↓	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no ↓	Was pegfilgrastim given this cycle? (e.g. Neulasta) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
PRIMARY REASON for Dose Adjustment per Section 8.0. Not BSA changes. (Check one)	35 <input type="checkbox"/> Hematologic 44 <input type="checkbox"/> Mucositis/stomatitis 97 <input type="checkbox"/> Infection 45 <input type="checkbox"/> Rash/desquamation 42 <input type="checkbox"/> Diarrhea 70 <input type="checkbox"/> Neurologic 50 <input type="checkbox"/> Hepatic 99 <input type="checkbox"/> Other (not per protocol) _____	35 <input type="checkbox"/> Hematologic 66 <input type="checkbox"/> Hand-foot skin reaction 42 <input type="checkbox"/> Diarrhea 44 <input type="checkbox"/> Mucositis/stomatitis 97 <input type="checkbox"/> Infection 50 <input type="checkbox"/> Hepatic 99 <input type="checkbox"/> Other (not per protocol) _____	99 <input type="checkbox"/> Other (not per protocol) _____	Was any erythropoietin product given this cycle? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No ↓ Specify _____

NORTH CENTRAL CANCER TREATMENT GROUP

NADIR/ADVERSE EVENT LOG (continuation)

Protocol # N0432

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

ALL ITEMS MUST BE COMPLETED

page 2 of 3

Amended Data: if yes, check box and **highlight** amended areas

Nadirs/Adverse Events associated with treatment cycle :

Adverse Event CTCAE v. 3.0	MedDRA Code v. 6.0 (must be completed)	Grade (highest grade this cycle) INCLUDE GRADE 0's	Relationship to Study Medication If Grade > 0 1 = Not related 2 = Unlikely 3 = Possible 4 = Probable 5 = Definite	AER* Check if sub- mitted
Rash: hand-foot skin reaction	1 0 0 2 4 7 7 2	0 1 2 3 4 5	1 2 3 4 5	1 <input type="checkbox"/>
Diarrhea	1 0 0 1 2 7 4 5	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Mucositis/stomatitis (functional/ symptomatic) - Oral cavity	1 0 0 4 2 1 2 8	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Mucositis/stomatitis (functional/ symptomatic) - Pharynx	9 0 0 3 0 0 6 4	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Nausea	1 0 0 2 8 8 1 3	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Vomiting	1 0 0 4 7 7 0 6	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Hemorrhage, CNS	1 0 0 1 9 0 1 6	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Hemorrhage, GI - Lower GI NOS	1 0 0 5 0 9 5 3	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Hemorrhage, GI - Upper GI NOS	9 0 0 3 0 1 3 0	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Hemorrhage, pulmonary/upper respiratory - Lung	1 0 0 3 7 3 9 4	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Hemorrhage, pulmonary/upper respiratory - Nose	1 0 0 1 5 0 9 0	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Hemorrhage, pulmonary/upper respiratory - Respiratory tract NOS	1 0 0 3 8 7 2 9	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Febrile neutropenia (fever of unknown origin without clinically or microbiologically documented infection) (ANC <1.0 x 10 ⁹ /L, fever ≥38.5°C)	1 0 0 1 6 2 8 8	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Infection with normal ANC or grade 1 or 2 neutrophils - Lung (pneumonia)	1 0 0 3 5 7 2 5	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>

* See Section 10.0 of the protocol.

** Both hematologic (except for the nadirs listed on page 1) and nonhematologic Adverse Events must be graded on this form as applicable.

NORTH CENTRAL CANCER TREATMENT GROUP

NADIR/ADVERSE EVENT LOG (continuation)

Protocol # N0432

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

ALL ITEMS MUST BE COMPLETED

page 3 of 3

Amended Data: if yes, check box and **highlight** amended areas

Nadirs/Adverse Events associated with treatment cycle :

Adverse Event CTCAE v. 3.0	MedDRA Code v. 6.0 (must be completed)	Grade (highest grade this cycle) INCLUDE GRADE 0's	Relationship to Study Medication If Grade > 0 1 = Not related 2 = Unlikely 3 = Possible 4 = Probable 5 = Definite	AER* Check if sub- mitted
Proteinuria	1 0 0 3 7 0 3 2	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
CNS cerebrovascular ischemia	1 0 0 0 8 1 2 0	0 <input checked="" type="checkbox"/> 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Neuropathy: motor	1 0 0 3 4 5 8 0	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Neuropathy: sensory	1 0 0 3 4 6 2 0	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Pain - Musculoskeletal - Bone	1 0 0 0 6 0 0 2	0 1 2 3 4 <input checked="" type="checkbox"/>	1 2 3 4 5	1 <input type="checkbox"/>
Pain - Musculoskeletal - Muscle	1 0 0 2 8 4 1 1	0 1 2 3 4 <input checked="" type="checkbox"/>	1 2 3 4 5	1 <input type="checkbox"/>
Thrombosis/thrombus/embolism	1 0 0 4 3 6 0 7	0 <input checked="" type="checkbox"/> 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Neurology - Other (Reversible Posterior Leukoencephalopathy Syndrome [RPLS] or similar leukoencephalopathy)	9 0 0 0 4 0 7 8	0 1 2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>

Adverse Events beyond those required in Section 10.0 of the protocol.
Record grade 2 with attribution of possible, probable or definite and all grade
3, 4 and 5 regardless of attribution.**

Other:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Other:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Other:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Other:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Other:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>
Other:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2 3 4 5 (death)	1 2 3 4 5	1 <input type="checkbox"/>

* See Section 10.0 of the protocol.

** Both hematologic (except for the nadirs listed on page 1) and nonhematologic Adverse Events must be graded on this form as applicable.

Protocol # N0432

Patient ID # _____ Initials: _____

Local ID # _____ Institution _____ L F M

NORTH CENTRAL CANCER TREATMENT GROUP

RECIST MEASUREMENT FORM

ALL ITEMS MUST BE COMPLETED

Amended Data: if yes, check box and **highlight** amended areas

Is this: (check one) 1 Initial Treatment 2 Retreatment after PD (CR Patients only)

	Pretreatment	Cycle <input type="text"/>	Cycle <input type="text"/>
Assessment Date (mm/dd/yyyy)	<input type="text"/>	<input type="text"/>	<input type="text"/>

INSTRUCTIONS

- Record the top ten target lesions (refer to protocol).
- Measure target lesions in cm. using longest diameter (one dimension only).
- Record measurements at on study, scheduled reevaluation, and progression.
- Maintain same type of assessment throughout study.
- Record presence or absence of non-target lesions at baseline, thereafter record the status of non-target lesions at each required evaluation.
- Overall objective status is determined by combining status of target lesions, non-target lesions and new lesions (refer to protocol Section 11).

Overall Objective Status (check one)

19 N/A (not applicable this cycle) → End Form

1 CR*

2 PR*

5 SD

6 PD* (complete end of active treatment and event monitoring forms)

• Did pt develop new lesions?
1 Yes 2 No

• Prog due only to Clinical Deterioration?
1 Yes 2 No

Overall Objective Status (check one)

19 N/A (not applicable this cycle) → End Form

1 CR*

2 PR*

5 SD

6 PD* (complete end of active treatment and event monitoring forms)

• Did pt develop new lesions?
1 Yes 2 No

• Prog due only to Clinical Deterioration?
1 Yes 2 No

Overall Objective Status (check one)

19 N/A (not applicable this cycle) → End Form

1 CR*

2 PR*

5 SD

6 PD* (complete end of active treatment and event monitoring forms)

• Did pt develop new lesions?
1 Yes 2 No

• Prog due only to Clinical Deterioration?
1 Yes 2 No

Target Lesion Site(s)	Type of Assessment					Measurement (cm)	Measurement (cm)	Measurement (cm)
	PE	CT	Spiral CT	MRI	CXR			
1	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
2	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
3	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
4	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
5	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
6	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
7	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
8	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
9	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
10	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
Sum of all Lesions								

Non-Target Lesions	1 <input type="checkbox"/> Present 2 <input type="checkbox"/> Absent	5 <input type="text"/>	9 <input type="text"/>	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	5 <input type="text"/>	9 <input type="text"/>	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
	Change 5 = Not Done 9 = Not Applicable 1 = CR 2 = NonCR/NonPD 3 = PD										

* Submit documentation to verify CR, PR, PD.

NORTH CENTRAL CANCER TREATMENT GROUP

RECIST MEASUREMENT FORM (continuation)

ALL ITEMS MUST BE COMPLETED

Amended Data: if yes, check box and highlight amended areas

Protocol # N0432

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

	Cycle <input type="text"/> <input type="text"/>	Cycle <input type="text"/> <input type="text"/>	Cycle <input type="text"/> <input type="text"/>
Assessment Date (mm/dd/yyyy)	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

INSTRUCTIONS 1. Record the top ten target lesions (refer to protocol). 2. Measure target lesions in cm. using longest diameter (one dimension only). 3. Record measurements at on study, scheduled reevaluation, and progression. 4. Maintain same type of assessment throughout study. 5. Record presence or absence of non-target lesions at baseline, thereafter record the status of non-target lesions at each required evaluation. 6. Overall objective status is determined by combining status of target lesions, non-target lesions and new lesions (refer to protocol Section 11).	Overall Objective Status (check one) 19 <input type="checkbox"/> N/A (not applicable this cycle) → End Form 1 <input type="checkbox"/> CR* 2 <input type="checkbox"/> PR* 5 <input type="checkbox"/> SD 6 <input type="checkbox"/> PD* (complete end of active treatment and event monitoring forms) ↓ • Did pt develop new lesions? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No • Prog due only to Clinical Deterioration? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Overall Objective Status (check one) 19 <input type="checkbox"/> N/A (not applicable this cycle) → End Form 1 <input type="checkbox"/> CR* 2 <input type="checkbox"/> PR* 5 <input type="checkbox"/> SD 6 <input type="checkbox"/> PD* (complete end of active treatment and event monitoring forms) ↓ • Did pt develop new lesions? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No • Prog due only to Clinical Deterioration? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Overall Objective Status (check one) 19 <input type="checkbox"/> N/A (not applicable this cycle) → End Form 1 <input type="checkbox"/> CR* 2 <input type="checkbox"/> PR* 5 <input type="checkbox"/> SD 6 <input type="checkbox"/> PD* (complete end of active treatment and event monitoring forms) ↓ • Did pt develop new lesions? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No • Prog due only to Clinical Deterioration? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
---	---	---	---

Target Lesion Site(s)	Type of Assessment					Measurement (cm)	Measurement (cm)	Measurement (cm)
	PE	CT	Spiral CT	MRI	CXR			
1	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
2	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
3	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
4	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
5	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
6	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
7	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
8	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
9	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
10	1 <input type="checkbox"/>	2 <input type="checkbox"/>	13 <input type="checkbox"/>	3 <input type="checkbox"/>	5 <input type="checkbox"/>			
Sum of all Lesions								

Non-Target Lesions	1 <input type="checkbox"/> Present 2 <input type="checkbox"/> Absent	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
		Change 5 = Not Done 9 = Not Applicable 1 = CR 2 = NonCR/NonPD 3 = PD	

* Submit documentation to verify CR, PR, PD.

10/14/04
Measurable

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

EVENT MONITORING FORM
(Progression/Recurrence, Follow-up, New Primary, Death)

Protocol # N0432

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

Amended Data: if yes, check box and **highlight** amended areas

Were you able to obtain any information about the patient since the last report?*

1 Yes 2 No → Date of last attempt to contact patient: / / → Return form to Operations Office
m m d d y y y y

VITAL STATUS

1 Alive } Date last known alive or death: / /
2 Dead } m m d d y y y y

Cause of death 1 This cancer 4 Adverse Event
3 Other cancer, specify _____ 2 Other, specify _____

DISEASE FOLLOW UP STATUS

Has the patient been assessed for this cancer since submission of the last event monitoring form?*

2 No → Go to Notice of New Primary.
1 Yes. If Yes, Date of Assessment: / /
m m d d y y y y

NOTICE OF RELAPSE/PROGRESSION

Has the patient had a relapse/progression of this cancer that has not been previously reported?

2 No 1 Yes. If Yes, Date of Relapse:** / /
m m d d y y y y

Site(s) of Relapse/Progression: (check all that apply) Bone Lung Skin
 Liver Nodes Chestwall
 Brain Other, Specify _____

Method(s) of Diagnosis: (check all that apply) Physical Exam MRI Chest X-ray
 CT ULT Patient coorespondence
 Other, specify _____

SUBSEQUENT TREATMENT

Has the patient received subsequent treatment for this cancer that has not been previously reported?

1 Yes 2 No 3 Unknown
Date of subsequent treatment: / / Specify subsequent treatment: _____
m m d d y y y y

NOTICE OF NEW PRIMARY

Has a new malignant neoplasm or myelodysplastic syndrome (MDS) been diagnosed that has not been previously reported?

2 No 3 Unknown 1 Yes. If Yes, Date of New Primary: / /
m m d d y y y y

Specify New Primary Site: _____

LATE ADVERSE EVENT (post completion of active monitoring)

Has the patient developed any of the following not previously reported:

- Adverse events at least possibly attributed to treatment on this study.
- Death within 30 days of treatment.
- Death any time at least possibly treatment related.

2 No 3 Unknown/ Not evaluated 1 Yes
↓
Submit Event Monitoring Continuation Form for Late Adverse Event Reporting

* If this is the first event monitoring form check yes, enter assessment date and complete the rest of the form.
** Submit documentation to verify PROG.

NORTH CENTRAL CANCER TREATMENT GROUP

EVENT MONITORING CONTINUATION FORM

(LATE ADVERSE EVENT REPORTING)

ALL ITEMS MUST BE COMPLETED

Amended Data: if yes, check box and highlight amended areas

Protocol # N0432

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

LATE ADVERSE EVENTS

The CTCAE Version 3.0 will be used to evaluate the following signs/symptoms:

Adverse Event CTCAE v. 3.0	MedDRA Code v. 6.0 (must be completed)	Highest Grade	Relationship to Study Medication 1 = Not related 2 = Unlikely 3 = Possible 4 = Probable 5 = Definite	Late Adverse Event Start Date (mm/dd/yyyy)
Other:	<input type="text"/>	1 2 3 4 5 (death)	1 2 3 4 5	<input type="text"/> / <input type="text"/> / <input type="text"/>
Other:	<input type="text"/>	1 2 3 4 5 (death)	1 2 3 4 5	<input type="text"/> / <input type="text"/> / <input type="text"/>
Other:	<input type="text"/>	1 2 3 4 5 (death)	1 2 3 4 5	<input type="text"/> / <input type="text"/> / <input type="text"/>
Other:	<input type="text"/>	1 2 3 4 5 (death)	1 2 3 4 5	<input type="text"/> / <input type="text"/> / <input type="text"/>
Other:	<input type="text"/>	1 2 3 4 5 (death)	1 2 3 4 5	<input type="text"/> / <input type="text"/> / <input type="text"/>
Other:	<input type="text"/>	1 2 3 4 5 (death)	1 2 3 4 5	<input type="text"/> / <input type="text"/> / <input type="text"/>
Other:	<input type="text"/>	1 2 3 4 5 (death)	1 2 3 4 5	<input type="text"/> / <input type="text"/> / <input type="text"/>
Other:	<input type="text"/>	1 2 3 4 5 (death)	1 2 3 4 5	<input type="text"/> / <input type="text"/> / <input type="text"/>
Other:	<input type="text"/>	1 2 3 4 5 (death)	1 2 3 4 5	<input type="text"/> / <input type="text"/> / <input type="text"/>
Other:	<input type="text"/>	1 2 3 4 5 (death)	1 2 3 4 5	<input type="text"/> / <input type="text"/> / <input type="text"/>
Other:	<input type="text"/>	1 2 3 4 5 (death)	1 2 3 4 5	<input type="text"/> / <input type="text"/> / <input type="text"/>
Other:	<input type="text"/>	1 2 3 4 5 (death)	1 2 3 4 5	<input type="text"/> / <input type="text"/> / <input type="text"/>
Other:	<input type="text"/>	1 2 3 4 5 (death)	1 2 3 4 5	<input type="text"/> / <input type="text"/> / <input type="text"/>
Other:	<input type="text"/>	1 2 3 4 5 (death)	1 2 3 4 5	<input type="text"/> / <input type="text"/> / <input type="text"/>

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

**BASELINE BLOOD
SPECIMEN SUBMISSION FORM**

Protocol # N0432

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

INSTRUCTIONS

Complete this form **for all patients** and submit directly to the Operations Office within 14 days of study entry. See Section 14 of the protocol for specimen requirements and shipment.

Did this patient consent to provide blood specimen(s) for research?

1 Yes —→ Complete rest of form.

2 No —→ End form.

Was a research blood specimen collected?

1 Yes Date of collection: / /
m m d d y y y y

2 No Reason: _____

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP
NOTIFICATION FORM

Protocol # N0432

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

Grade 4 or 5 Non-AER Reportable Events/Hospitalization

INSTRUCTIONS:

- Use this form to report all known information on non-AER reportable grade 4 or 5 adverse events or any hospitalization during active treatment.
- If AER has been submitted for this event do not enter this form.
- Fill out all information known.
- Enter into the remote data entry system within 5 working days of notification.
- These events must also be reported on the Nadir/Adverse Event Form.

Date membership CRA aware of event(s): (mm/dd/yyyy) ___/___/_____

Name of Person Completing Form: _____ Phone Number (____) _____ - _____

Cycle Number: _____ Assigned Treatment Arm: _____

Event ≥ Grade 4 1 Yes 2 No



Date of First Occurrence of Adverse Event (mm/dd/yyyy)	Common Toxicity Criteria Adverse Event Term Type (only one event per line)	CTC Adverse Event Grade	Relationship to study medication. In your opinion, is this related to the study medication? ¹
___/___/_____		<input type="checkbox"/> 4 <input type="checkbox"/> 5	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown
___/___/_____		<input type="checkbox"/> 4 <input type="checkbox"/> 5	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown
___/___/_____		<input type="checkbox"/> 4 <input type="checkbox"/> 5	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown
___/___/_____		<input type="checkbox"/> 4 <input type="checkbox"/> 5	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown
___/___/_____		<input type="checkbox"/> 4 <input type="checkbox"/> 5	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown

1. Answer YES if attribution is unlikely, possible, probable or definite; answer NO if unrelated; answer UNKNOWN if you are not sure.

Hospitalization: 1 Yes 2 No

↓
Hospital Admission Date: (mm/dd/yyyy) ___/___/_____

Reason(s) for Hospitalization:

1 Adverse Event, specify type and grade: _____

2 Prophylactic, specify: _____

3 Other reason, specify _____

Mayo Central Laboratory for Clinical Trials

Fax Supply Order Form – No Cover Sheet Necessary
Fax to Ja-Neen Bird at 1-507-266-0188

NCCTG
PROTOCOL:N0432

Account # CT204641

Investigator: _____

Order Placed By: _____

Phone #:(____) _____

Fax #:(____) _____

Address(kits sent to):

Today's Date: _____

YOU WILL RECEIVE YOUR SUPPLIES WITHIN 2 WEEKS OF TODAY'S DATE.

Please call 1-800-826-5561 if you have questions about this order.

Number of Research Testing Kits: _____

Other Supplies:

Supplies needed for Federal Express® service only:

5 lb. Refrigerate Mailer (Refrigerate; non-infectious) _____

Federal Express® Air Bills (Refrigerate; non-infectious) _____

(Numbers of these supplies should equal the number of kits requested)

Questions? Call Ja-Neen Bird at 800-826-5561