

FORMS PACKET**N0572, A Phase I/II Trial of Sorafenib and CCI-779 in Patients with Recurrent Glioblastoma**

Contents:	
	Pre-Registration Eligibility checklist (11/6/09)
✓	Eligibility checklist (9/28/11)
	Forms completion instructions (11/14/02)
	Concurrent treatment log (2/10/06)
	Anticonvulsant concurrent treatment log (baseline) (2/10/06)
	Anticonvulsant concurrent treatment log (active monitoring phase) (2/10/06)
	Steroid concurrent treatment log (baseline) (2/10/06)
	Steroid concurrent treatment log (active monitoring phase) (2/10/06)
	On-study form (2/10/06)
	Baseline adverse events/symptoms (2/10/06)
	Pretreatment neuro measurement form (12/20/05)
	Active monitoring measurement form (2/10/06)
	Evaluation/treatment form (1/5/11)
	Nadir/adverse event log (7/13/06)
	Active monitoring lipid panel form (2/21/06)
	CTEP report variables (4/17/09)
	End of active treatment form (12/20/06)
	Event monitoring form (12/21/06)
	Pathology reporting form (4/13/07)
	Pathology submission form (4/13/07)
	Tissue submission form (11/19/10)
	Active monitoring (non surgical patients) Blood specimen submission form (12/20/10)
	Active monitoring (surgery patients) Blood specimen submission form (12/20/10)
	Preregistration screening failure form (5/1/06)
	Grade 4 or 5 non-AER reportable events/hospitalization form (2/10/06)
	Fax supply order form

✓ designates revised/new forms

*Generic forms completion instructions are available on the NCCTG web site under “the CRA link in the Remote Registration and Data Entry section and are titled “Remote Data Entry Screen Instructions (Forms Completion).”

The specific forms instructions take precedence over the generic forms instructions, so it is very important to review them in addition to the generic forms instructions.

NORTH CENTRAL CANCER TREATMENT GROUP

Pre-Registration (Step 1) Eligibility Checklist

11/06/2009

Page 1 of 2

N0572: **A Pilot and Phase II Trial of Sorafenib and CCI-779 in Patients with Recurrent Glioblastoma**

To pre-register a patient, call (507/284-4130) or fax (507/284-0885) a completed (Step 1) pre-registration eligibility checklist to the Registration Office between 8 a.m. and 4:30 p.m. Central time Monday through Friday.

Has the patient ever been on a prior study entered through this Registration Office? Yes No

If yes: Prior study number _____; prior patient study ID number _____

Registration date (date on) (mm/dd/yyyy) __/__/____

Patient study ID number (provided at time of Reg/Random) _____

NCCTG member (participant sponsor) _____

NCCTG treating location _____

NCCTG treating physician _____

Institution patient number (local subject number) _____

IRB approval date (mm/dd/yyyy) __/__/____

Person Completing Form:

Last Name: (print) _____ First Name: (print) _____

Phone: _____ Fax: _____ Email: _____

Patient initials (last, first, middle) _____

(For Mayo Rochester patients, include first four letters of last name.)

Gender (check one) Male Female Unknown

Date of birth (mm/dd/yyyy) __/__/____

Zip code _____

Country of Residence _____

Race (check all that apply)

- White
- Black or African American
- Native Hawaiian or Other Pacific Islander
- Asian
- American Indian or Alaska Native
- Not reported: Patient refused or not available
- Unknown: Patient unsure

Method of payment (check one)

- PI (Private Insurance)
- MR (Medicare)
- MRP (Medicare and Private Insurance)
- MD (Medicaid)
- MM (Medicaid and Medicare)
- MVA (Military or Veterans Sponsored,
Not Otherwise Specified (NOS))
- MS (Military Sponsored [including CHAMPUS & TRCARE])
- MV (Veterans Sponsored)
- SP (Self pay [no insurance])
- NP (No means of payment [no insurance])
- OTH (Other)
- UNK (Unknown)

Ethnicity (check one)

- Not Hispanic or Latino
- Hispanic or Latino
- Not reported: Refused or data not available
- Unknown: Unsure of their ethnicity

NCCTG Pre-registration (Step 1) Eligibility Checklist N0572

11/06/2009
Page 2 of 2

Patient Study ID number _____

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

Yes No

Required Characteristic

____ Central pathology review submission. This review is mandatory prior to registration to confirm eligibility.

It should be initiated as soon after surgery as possible.

Response in above section must be “Yes.”

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 a 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**) ____.

____ The site has reviewed and understands the process listed in Section 17.0 and must account for sufficient time to complete pre-registration and registration steps.

All responses in above section must be “Yes.”

Assigned Treatment

____ Pre-registration

Person registering Signature _____ Registration Office specialist Initials _____

Physician Signature _____ Date (mm/dd/yyyy) ____/____/____

NORTH CENTRAL CANCER TREATMENT GROUP

Registration (Step 2) Eligibility Checklist

9/28/2011
Page 1 of 6

N0572: A Phase I/II Trial of Sorafenib and CCI-779 in Patients with Recurrent Glioblastoma

To register a patient, call (507/284-4130) or fax (507/284-0885) a completed (Step 2) registration eligibility checklist to the Registration Office between 8 a.m. and 4:30 p.m. central time Monday through Friday.

Has the patient ever been on a prior study entered through this Registration Office? Yes No

If yes: Prior study number _____; prior patient study ID number _____

Registration date (date on) (mm/dd/yyyy) ___/___/_____

Patient study ID number (provided at time of Reg/Random) _____

NCCTG member (participant sponsor) _____

NCCTG treating location _____

NCCTG treating physician _____

Institution patient number (local subject number) _____

IRB approval date (mm/dd/yyyy) ___/___/_____

Person Completing Form:

Last Name: (**print**) _____ First Name: (**print**) _____

Phone: _____ Fax: _____ Email: _____

Patient initials (last, first, middle) _____
(For Mayo Rochester patients, include first four letters of last name.)

Gender (check one) Male Female Unknown

Date of birth (mm/dd/yyyy) ___/___/_____

Zip code _____

Country of Residence _____

Race (check all that apply)

- White
- Black or African American
- Native Hawaiian or Other Pacific Islander
- Asian
- American Indian or Alaska Native
- Not reported: Patient refused or not available
- Unknown: Patient unsure

Method of payment (check one)

- PI (Private Insurance)
- MR (Medicare)
- MRP (Medicare and Private Insurance)
- MD (Medicaid)
- MM (Medicaid and Medicare)
- MVA (Military or Veterans Sponsored,
Not Otherwise Specified (NOS))
- MS (Military Sponsored [including CHAMPUS & TRCARE])
- MV (Veterans Sponsored)
- SP (Self pay [no insurance])
- NP (No means of payment [no insurance])
- OTH (Other)
- UNK (Unknown)

Ethnicity (check one)

- Not Hispanic or Latino
- Hispanic or Latino
- Not reported: Refused or data not available
- Unknown: Unsure of their ethnicity

Patient study ID 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

- ____ ____ ≤2 prior systemic chemotherapy regimens.
- ____ ____ ≥18 years of age. Age = _____.
- ____ ____ Histological confirmation of a grade 4 astrocytoma (glioblastoma) or gliosarcoma, at primary diagnosis or recurrence by WHO criteria (see Section 17.0). Central pathology review is mandatory prior to study entry to confirm eligibility.
- ____ ____ Evidence of tumor progression by MRI or CT scan following RT or following the most recent anti-tumor therapy.
- ____ ____ Bidimensionally measurable or evaluable disease by MRI or CT scan.
- ____ ____ ECOG Performance Status (PS) 0, 1, or 2.
- ____ ____ ≥12 weeks since the completion of RT. Last day of RT ____ - ____ - ____ vs. not applicable ____.
- ____ ____ Fixed or decreasing dose of corticosteroids (or no corticosteroids) ≥1 week prior to registration.
- ____ ____ Corticosteroids start date ____ - ____ - ____ vs. not applicable ____.
- ____ ____ ≥1 week from minor surgery other than venous line placement and >3 weeks from major surgery (except for patients undergoing tumor tissue acquisition as discussed in Section 7).
- ____ ____ Date of minor surgery ____ - ____ - ____ vs. not applicable ____.
- ____ ____ Date of major surgery ____ - ____ - ____ vs. not applicable ____.
- ____ ____ ≥4 weeks from prior cytotoxic chemotherapy (≥6 weeks for nitrosoureas).
- ____ ____ Last day of cytotoxic chemotherapy ____ - ____ - ____ vs. not applicable ____.
- ____ ____ Last day of nitrosoureas ____ - ____ - ____ vs. not applicable ____.
- ____ ____ ≥2 weeks from cytostatic chemotherapy such as tamoxifen, cis-retinoic acid, or thalidomide (address questions regarding such agents to study chair).
- ____ ____ Last day of cytostatic chemotherapy ____ - ____ - ____ vs. not applicable ____.
- ____ ____ The following laboratory values obtained ≤7 days prior to registration. Earliest laboratory test date ____ - ____ - ____; latest laboratory test date ____ - ____ - ____ . NOTE: These dates pertain to the following labs only.
 - ____ ____ • WBC ≥3000/mm³. WBC = _____.
 - ____ ____ • ANC ≥1500/mm³. ANC = _____.
 - ____ ____ • PLT ≥100,000/mm³. PLT = _____.
 - ____ ____ • Hgb ≥10 gm/dL. Hgb = _____.
 - ____ ____ • Total bilirubin ≤1.5 x ULN. Note see section 7.2 for starting dose of temsirolimus if bilirubin is >1.0 and ≤1.5 x ULN
Total bilirubin = _____; ULN = _____.
 - ____ ____ • SGOT (AST) ≤2.5 x ULN. SGOT (AST) = _____; ULN = _____.
 - ____ ____ • Creatinine ≤2.0 x ULN. Creatinine = _____; ULN = _____.
 - ____ ____ • Serum cholesterol ≤350 mg/dL. Serum cholesterol = _____.
 - ____ ____ • Serum triglycerides ≤400 mg/dL. Serum triglycerides = _____.
- ____ ____ Willingness to provide the biologic specimens as required by the protocol. (Please note that the willingness to participate pertains only to the patient and does not factor in the institution's ability to participate in any part of the translational component.)

All responses in above section must be "Yes."

Contraindications

- ____ ____ Prior intratumoral chemotherapy (e.g. Gliadel or IL13-PE38QQR), stereotactic radiosurgery or interstitial brachytherapy unless there is a separate lesion on MRI which is not part of the previous treatment field or there is proof of recurrent disease based on biopsy, MRI spectroscopy, or PET scan.
- ____ ____ Prior CCI-779, sorafenib, or other agents specifically targeting mTOR or raf. Patients receiving prior agents inhibiting VEGF or VEGFR (prior anti-VEGF group) are eligible but: 1) must be at least four weeks from last treatment with the agent(s); and 2) must have recovered from any clinically relevant toxicities attributable to this agent(s).

Patient study ID number _____

Eligibility Check – Contraindications *(continued)*

Yes No

- | | | |
|-------|-------|--|
| _____ | _____ | Evidence of bleeding diathesis or coagulopathy. |
| | | <ul style="list-style-type: none"> • Note: Patients on prophylactic anticoagulation therapy (e.g., low-dose warfarin) are eligible provided their coagulation parameter levels are as follows: prothrombin time (INR; International Normalized Ratio of prothrombin time) <1.1 x institutional upper limit of normal. • Note: Patients on full-dose anticoagulants (e.g. warfarin) are eligible provided that both of the following criteria are met: a) the patient has an in-range INR (usually between 2 and 3) on a stable dose of oral anticoagulant or on a stable dose of low molecular weight heparin, and b) the patient has no active bleeding or pathological condition that carries a high risk of bleeding (e.g., tumor involving major vessels or known varices). |
| _____ | _____ | INR >1.5 (unless the patient is on full dose warfarin). |
| _____ | _____ | Receiving enzyme-inducing antiepileptic drugs (EIAEDs; e.g., phenytoin, fosphenytoin, carbamazepine, phenobarbital, or primidone) or any other potent CYP3A4 inducer such as rifampin or St. John’s Wort. Note: See Appendix IV for a complete list. |
| _____ | _____ | Any condition (e.g., gastrointestinal tract disease resulting in an inability to take oral medication or a requirement for IV alimentation, prior surgical procedures affecting absorption, or active peptic ulcer disease) that impairs their ability to swallow pills. |
| _____ | _____ | Hypertension with systolic blood pressure of >140 mmHg or diastolic pressure >90 mmHg. However, patients with well-controlled hypertension are eligible. |
| _____ | _____ | Uncontrolled infection. |
| _____ | _____ | Any of the following because CCI-779 and sorafenib are investigational agents whose genotoxic effects on the developing fetus and newborn are unknown: <ul style="list-style-type: none"> • Pregnant women • Nursing women • Men or women of childbearing potential who are unwilling to employ adequate contraception Women of childbearing potential and men must agree to use adequate contraception (hormonal or barrier method of birth control; abstinence) prior to study entry and for the duration of study participation. Should a woman become pregnant or suspect she is pregnant while participating in this study, she should inform her treating physician immediately. |
| _____ | _____ | Known hypersensitivity to any of the components of CCI-779 or sorafenib. |
| _____ | _____ | Other active malignancy. |
| _____ | _____ | Uncontrolled intercurrent illness including, but not limited to, ongoing or active infection, symptomatic congestive heart failure, unstable angina pectoris, cardiac arrhythmia, or psychiatric illness/social situations that would limit compliance with study requirements. |
| _____ | _____ | Immunocompromised patients (other than that related to the use of corticosteroids) including patients known to be HIV positive. HIV-positive patients on combination antiretroviral therapy are ineligible because of the potential for pharmacokinetic interactions with CCI-779 and sorafenib. |
| _____ | _____ | Receiving any investigational agents other than CCI-779 or sorafenib. |
| _____ | _____ | Significant intratumoral, intracerebral, or subarachnoid hemorrhage on baseline MRI or CT, or other history of significant intratumoral, intracerebral, or subarachnoid hemorrhage. |

All responses in above section must be “No.”

NCCTG Registration (Step 2) Eligibility Checklist N0572

9/28/2011
Page 4 of 6

Patient study ID number _____

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

Yes No

- ____ ____ A mandatory translational research component is part of this study; the patient will be automatically registered on this component (Section 3.29e and 14.111).
- ____ ____ 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 ≤ 14 days after registration.
- ____ ____ Pretreatment tests/procedures must be completed ≤ 21 days prior to registration (see Section 4.0). Earliest pretreatment test date ____ - ____ - ____; latest pretreatment test date ____ - ____ - _____. NOTE: The earliest pretreatment test date(s) 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(s).
- Exceptions to the above dates:***
- Hematology, chemistry, and serum pregnancy test, for women of childbearing potential only, ≤ 7 days prior to registration (see Section 4.0).
Earliest exception test date ____ - ____ - ____; latest exception test date ____ - ____ - ____.
- ____ ____ If serum pregnancy test not done, reason: _____.
- ____ ____ All required baseline symptoms must be documented and graded.
- ____ ____ Study drug availability checked.
- ____ ____ Blood draw kit availability checked.

All responses in above section must be “Yes.”

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

- ____ ____ • Patient has given permission to keep tissue sample(s) for use in future research to learn about, prevent, or treat cancer.
- ____ ____ • Patient has given permission to keep blood sample(s) for use in future research to learn about, prevent, or treat cancer.
- ____ ____ • Patient has given permission to keep tissue sample(s) for use in future research to learn about, prevent, or treat other health problems (for example: diabetes, Alzheimer’s disease, or heart disease).
- ____ ____ • Patient has given permission to keep blood sample(s) for use in future research to learn about, prevent, or treat other health problems (for example: diabetes, Alzheimer’s disease, or heart disease).
- ____ ____ • Patient has given permission for his/her tissue sample to be used for genetic research.
- ____ ____ • Patient has given permission for his/her blood sample to be used for genetic research.
- ____ ____ • Patient has given NCCTG permission to give his/her tissue sample(s) to outside researchers.
- ____ ____ • Patient has given NCCTG permission to give his/her blood sample(s) to outside researchers.
- ____ ____ • Patient has given permission to be contacted in the future to take part in more research.

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

Patient study ID number _____

Grouping Factors

Phase I

NA Non-surgical patients only (PHASE I CLOSED TO ACCRUAL AS OF ADDENDUM 5)

Phase II (PHASE II OPENED TO ACCRUAL AS OF ADDENDUM 5)

NA Group 1: Patients not undergoing biopsy/surgery following study drug exposure
[Study 2, Group 1 (Arm B) only (CLOSED TO ACCRUAL AS OF 9/27/2011)]

_____ Group 2: Patients undergoing biopsy/surgery following study drug exposure

_____ Group 3: Patients with prior anti-VEGF treatments

Descriptive Factors

Age (years)

_____ ≤40

_____ 41-60

_____ >60

Non-enzyme inducing

anticonvulsant use at study entry

_____ Yes

_____ No

ECOG PS

_____ 0

_____ 1

_____ 2

Prior temozolomide

_____ Yes

_____ No

Prior nitrosoureas

_____ Yes

_____ No

Interval since end of RT

(months): _____

Corticosteroid therapy
at study entry

_____ Yes

_____ No

Extent of primary resection

_____ None

_____ Biopsy

_____ Subtotal resection

_____ Gross total resection

Extent of resection at
recurrence

_____ None

_____ Biopsy

_____ Subtotal resection

_____ Gross total resection

Family history of brain tumor

_____ Yes → If yes, check all that apply

_____ Father

_____ Mother

_____ Brother/Sister

_____ Child

_____ Other (list: _____)

_____ No

Primary indicator

_____ Measurable

_____ Evaluable

Prior treatment with anti-VEGF/VEGR or
VEGF kinase agents

_____ Yes

_____ No

Baseline total bilirubin

_____ ≤1.0 x ULN

_____ >1.0 x ULN

Subgroup code (for Full CDUS reporting):

NA SG1 Phase I Patients with recurrent GBM's

NA SG2 Phase II Patients not undergoing biopsy/surgery following study drug exposure
[Study 2, Group 1 (Arm B) only (CLOSED TO ACCRUAL AS OF 9/27/2011)]

_____ SG3 Phase II Patients undergoing biopsy/surgery following study drug exposure

_____ SG4 Phase II Patients with prior anti-VEGF treatments

NCCTG Registration (Step 2) Eligibility Checklist N0572

9/28/2011
Page 6 of 6

Patient study ID number _____

Assigned Treatment

- NA A) CCI-779* + Sorafenib** [*Phase I only (PHASE I CLOSED TO ACCRUAL AS OF ADDENDUM 5)*]
NA B) CCI-779* + Sorafenib** (Patients NOT undergoing biopsy/surgery) [*Study 2, Group 1 (Arm B) only (CLOSED TO ACCRUAL AS OF 9/27/2011)*]
_____ C) CCI-779* + Sorafenib** (Patients undergoing biopsy/surgery)
_____ D) CCI-779* + Sorafenib** (Patients not undergoing biopsy/surgery AND with prior anti-VEGF treatments)

Phase II, Arm C, and Arm D: Record dose and level

*CCI-779: Dose = _____ mg/week; Level = _____

**Sorafenib: Dose = _____ bid; Level = _____

Person registering Signature _____ Registration Office specialist initials _____

Physician Signature _____ Date (mm/dd/yyyy) ____/____/____

Generic Instructions for Forms Completion

<p>General Information</p>	<ul style="list-style-type: none"> • All forms are protocol specific and contain only the data that is pertinent to the protocol's analysis. • Forms will be returned to the site if any of the fields have not been completed. • It is important to comply with the protocol's test schedule (Section 4.0). Not all protocol test schedule requirements will be captured/recorded on the forms; however, the tests/procedures are required for patient management. • All data items on the forms must be completed unless there are specific instructions on the form indicating that only one choice must be marked. <ul style="list-style-type: none"> ✓ Shaded areas or blank items do not need to be filled in.
<p>On-Study Form</p>	<ul style="list-style-type: none"> • Refer to Section 18.0 for submission of the On-Study Form. • For the majority of protocols, the On-Study Form must be submitted within 14 days of registration.
<p>Evaluation Treatment Form</p>	<ul style="list-style-type: none"> • NCCTG defines a cycle as the time treatment starts until the patient returns for reevaluation by the physician. • An Evaluation/Treatment Form must be submitted for each cycle of treatment and/or observation. <ul style="list-style-type: none"> ✓ The first cycle is number 1. ✓ The cycle number, treatment arm, performance score (PS), body surface area (BSA), treatment delay, and dose level refer to the agent's start date. ✓ The agent(s) and primary reason(s) for treatment delay(s) and dose adjustment(s) are prefilled on the form.
<p>Nadir/Adverse Event Log</p>	<ul style="list-style-type: none"> • All hematologic and non-hematologic adverse events (AEs) are collected on the Nadir/AE Log. • The evaluation date is the date the patient was evaluated by a physician before starting the next cycle of treatment or observation. Thus, the evaluation date may not be the same as the required laboratory tests/imaging studies. <i>Example:</i> If the CT scan was obtained on March 12, the laboratory tests were obtained on March 13, and the physician's evaluation of the patient occurred on March 14, the evaluation date is March 14.

***Nadir Adverse
Event Log
(continued)***

***Nadir values on
the
Nadir/Adverse
Event Log***

- Nadir value is the lowest value of a blood test occurring between two treatment cycles. The values obtained prior to the next treatment cycle are to be included in determining the nadir value. Therefore, the nadir could also be day 1 values used for retreatment.

Example 1. Nadirs occurring mid cycle:

Patient received his/her first cycle of treatment on October 12 and is returning for evaluation on November 9. The date of the WBC, ANC, and PLT nadirs is the same day, November 2.

Date	10/12	10/19	10/26	11/02	11/09
PLT K/uL or 10 ⁹ /L	140	100	90	80	100
WBC K/uL or 10 ⁹ /L	5.8	6.4	6.0	3.2	6.0
ANC K/uL or 10 ⁹ /L	4.5	3.4	3.3	1.0	4.1

Example 2. Nadir occurring on date of evaluation :

Patient received his/her first cycle of treatment on February 12 and is returning for evaluation on March 12. The date of the WBC and ANC nadir is March 12, and the PLT nadir is February 26.

Date	02/12	02/19	02/26	03/05	03/12
PLT K/uL or 10 ⁹ /L	120	100	70	80	100
WBC K/uL or 10 ⁹ /L	10.8	8.4	6.2	6.0	3.2
ANC K/uL or 10 ⁹ /L	7.5	4.4	3.3	1.1	1.0

Example 3. Delay treatment/nadir occurring after eval. date:

Patient received his/her second cycle of treatment on March 12 and is returning for evaluation on March 31. The date of the WBC nadir is March 31, ANC nadir is April 5, and PLT nadir is March 19. (The nadir for the ANC, WBC, and/or PLT can occur after the evaluation date.)

Date	03/12	03/19	03/26	03/31	04/05	04/09
PLT K/uL or 10 ⁹ /L	140	60	70	80	100	120
WBC K/uL or 10 ⁹ /L	9.8	7.4	4.2	2.2	2.3	3.5
ANC K/uL or 10 ⁹ /L	7.5	5.4	3.3	1.0	0.9	1.6

Example 4. Interval counts not done/not required:

Patient was last treated on 5/1 and is now returning for evaluation on 7/8 having no interval counts drawn. Nadirs will be the blood counts drawn on 7/8 as long as they are drawn prior to subsequent treatment. Since nadirs are not required on observation cycles, record the values obtained at the subsequent evaluation, i.e., 07/08.

<p>Nadir Adverse Event Log (continued)</p>	<table border="1"> <thead> <tr> <th>Date</th> <th>05/01</th> <th>05/08</th> <th>06/26</th> <th>07/01</th> <th>07/08</th> </tr> </thead> <tbody> <tr> <td>PLT K/uL or 10⁹/L</td> <td>215</td> <td>ND</td> <td>ND</td> <td>ND</td> <td>195</td> </tr> <tr> <td>WBC K/uL or 10⁹/L</td> <td>4.1</td> <td>ND</td> <td>ND</td> <td>ND</td> <td>4.6</td> </tr> <tr> <td>ANC K/uL or 10⁹/L</td> <td>5.2</td> <td>ND</td> <td>ND</td> <td>ND</td> <td>6.3</td> </tr> </tbody> </table>	Date	05/01	05/08	06/26	07/01	07/08	PLT K/uL or 10 ⁹ /L	215	ND	ND	ND	195	WBC K/uL or 10 ⁹ /L	4.1	ND	ND	ND	4.6	ANC K/uL or 10 ⁹ /L	5.2	ND	ND	ND	6.3
Date	05/01	05/08	06/26	07/01	07/08																				
PLT K/uL or 10 ⁹ /L	215	ND	ND	ND	195																				
WBC K/uL or 10 ⁹ /L	4.1	ND	ND	ND	4.6																				
ANC K/uL or 10 ⁹ /L	5.2	ND	ND	ND	6.3																				
<p>Selecting "Yes" for grading of adverse events</p>	<ul style="list-style-type: none"> • If the patient had even one adverse event, all required adverse events (prefilled on the form) and any other adverse events must be graded. • To indicate a serious AE has been reported, check the last column on the Nadir/Adverse Event Log. This information is required for NCI reporting. All events that have been included as serious events must be included on the expedited SAE. <i>Note: The last column does not need to be checked when only the NCCTG Grade 4 or 5 Notification Form was submitted.</i> • The "highest grade observed this cycle" (including grade 0) and the "relationship to study medication" (if the grade is >0) must be completed when grading required AEs (i.e. prefilled on the form and assessed at every evaluation) for a cycle of treatment/observation. <ul style="list-style-type: none"> ✓ Section 10 of the protocol must be reviewed prior to grading AEs. ✓ All grades, regardless of attribution, must be entered for required AEs. ✓ Adverse events beyond those specified in Section 10 of the protocol must have IMT/MedDRA codes, CTC description and grades, and relationships entered. 																								
<p>Selecting "No" for grading of adverse events</p>	<ul style="list-style-type: none"> • If the patient did not experience any adverse events for a cycle, check "No Adverse Events." Nothing further is required. <ul style="list-style-type: none"> ✓ If "No Adverse Events" is selected, submit only page one of the Nadir/Adverse Event Log. 																								
<p>Measurement Form</p>	<ul style="list-style-type: none"> • Before completing the Measurement Form, refer to Section 11 of the protocol to review the response and reporting criteria. • A Measurement Form must be submitted for each cycle of treatment/observation. • Date of tumor assessment is determined as follows: <ul style="list-style-type: none"> ✓ <i>Tumor assessment is not required:</i> Tumor assessment date is the date the patient was evaluated for further treatment, and the objective status is "N/A." ✓ <i>Tumor assessment is completed:</i> Tumor assessment date is 																								

<p>Measurement Form (continued)</p>	<p>the date the imaging study was completed (not the date the imaging study was interpreted).</p> <ul style="list-style-type: none"> ✓ <i>No progression/no response</i>: Tumor assessment date is the latest assessment date. ✓ <i>Progression/response</i>: Tumor assessment date is the date of the assessment that indicates the progression/response. <ul style="list-style-type: none"> • Both the target (measurable) and non-target (non-measurable) sections of the Measurement Form must be completed. • Always record the lesions in the same order. • At each required tumor assessment date: <ul style="list-style-type: none"> ✓ Record the sum of the target lesions. ✓ Record the change (status) of non-target lesions. • Record the overall objective status by combining the status of target lesions, non-target lesions and new lesions (refer to Section 11 of the protocol). • If overall objective status is response: <ul style="list-style-type: none"> ✓ Submit documentation to verify response. • If overall objective status is progression: <ul style="list-style-type: none"> ✓ Indicate if there were new lesions. ✓ If applicable, indicate if progression was due only to clinical deterioration. ✓ Submit documentation to verify progression.
<p>End of Active Treatment Form</p>	<ul style="list-style-type: none"> • The End of Active Treatment Form is submitted once per patient following the discontinuation of all protocol therapy. <i>Note:</i> Observation is not considered active treatment. • The “date of last treatment dose on this study” refers to the last date that the protocol treatment is administered. If there is a five-day treatment regimen (treatment begins on March 10 and ends on March 14) the “date of the last treatment dose on this study” is day 5—March 14. • The “date decision was made to end active treatment” corresponds to the date primary reason to discontinue active treatment was made. If the primary reason to discontinue treatment was progressive disease, the “date decision was made to end active treatment” is the date the physician evaluated the patient and confirmed progression.

<p>End of Active Treatment Form (continued)</p>	<ul style="list-style-type: none"> • Refer to the following when determining the primary reason for discontinuing the protocol: <ul style="list-style-type: none"> ✓ Completed Treatment Per Protocol: Patient completed all of the treatment required per protocol. ✓ Refused Further Treatment: Patient and/or patient's family refused further protocol treatment. ✓ Adverse Event: Complications, most likely related to protocol, or AEs making it medically necessary to stop protocol treatment. ✓ Disease Progression Before Active Treatment Started: Disease progression before any treatment on the protocol schema is given (e.g. surgery, chemotherapy, radiation, etc.). ✓ Disease Progression: Progressive disease or relapse during the active protocol treatment has been documented. ✓ Alternative Therapy: Patient was taken off protocol treatment to receive alternative non-protocol therapy. ✓ Other Medical Problems: Patient was removed from protocol treatment due to other medical problems not related to the protocol treatment. ✓ Died On Study: Patient died during the protocol's active treatment phase. ✓ Cytogenetic resistance: Resistance to the treatment by the tissue or tumor due to a genetic trait in the patient. ✓ New Primary/Secondary Malignancy: Patient was removed from protocol treatment due to new primary/secondary malignancy diagnosis. ✓ Other: Patient was removed from protocol treatment for other reasons (i.e., physician discretion, insurance/financial, family problems).
<p>Event Monitoring Form</p>	<ul style="list-style-type: none"> • The Event Monitoring Form is used to report progression, follow-up, new primary cancer, late adverse event, and/or death. • The "date of last attempt to contact the patient" is ONLY used when there is no new information to report since the submission of the last Event Monitoring Form. • Late Adverse Event section should be checked 'yes' under the following circumstances: <ul style="list-style-type: none"> ✓ Adverse event not previously reported post completion of the active monitoring phase. ✓ Adverse event not previously reported at least possibly attributed to treatment on the study.

<p><i>Event Monitoring Form (continued)</i></p>	<ul style="list-style-type: none"> ✓ Death within 30 days of treatment not due to disease progression. ✓ Death any time at least possibly treatment related.
<p><i>Event Monitoring Continuation Form (Late Adverse Event Reporting)</i></p>	<ul style="list-style-type: none"> • If 'yes' is checked for Late Adverse Event on the Event Monitoring Form, submit the continuation page of the Event Monitoring Form. • Adverse Events entered on this form must include the following: <ul style="list-style-type: none"> ✓ MedDRA codes ✓ CTC description and grading ✓ Late adverse event start date

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

Protocol # N0572

**PREFILLED
CONCURRENT TREATMENT LOG
ALL ITEMS MUST BE COMPLETED**

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

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

Baseline or Cycle #: _____

Evaluation Date: ___/___/___
(mm/dd/yyyy)

Concomitant Treatment
Antihypertensives? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Hyperglycemics? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Antidiarrheals? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Analgesics? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Antiemetics? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Blood product support? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Colony stimulating factors? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Erythropoietin? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP
ANTICONVULSANT
CONCURRENT TREATMENT LOG
(BASELINE)
ALL ITEMS MUST BE COMPLETED

Protocol # N0572

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

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

Evaluation Date: ___/___/___
(mm/dd/yyyy)

Is this patient taking anticonvulsant medication(s)?

1 Yes 2 No (*Stop here*)



Enter all anticonvulsants.

Anticonvulsant	Dose and Schedule

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

STEROID

CONCURRENT TREATMENT LOG

(BASELINE)

ALL ITEMS MUST BE COMPLETED

Protocol # N0572

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

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

Evaluation Date: ___/___/___
(mm/dd/yyyy)

Is this patient taking steroid medication(s)?

1 Yes 2 No (*Stop here*)



Enter all steroids.

Steroid	Dose and Schedule

PLACE LABEL HERE

**NORTH CENTRAL CANCER TREATMENT GROUP
ANTICONVULSANT
CONCURRENT TREATMENT LOG
(ACTIVE MONITORING PHASE)
ALL ITEMS MUST BE COMPLETED**

Protocol # N0572

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

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

Cycle: _____

Evaluation Date: ____/____/____
(mm/dd/yyyy)

Has there been any change in anticonvulsant medication(s) since previous visit?

1 Yes 2 No (*Stop here*)



Enter all anticonvulsants

Anticonvulsant	Dose and Schedule

PLACE LABEL HERE

**NORTH CENTRAL CANCER TREATMENT GROUP
STERIODS**

**CONCURRENT TREATMENT LOG
(ACTIVE MONITORING PHASE)
ALL ITEMS MUST BE COMPLETED**

Protocol # N0572

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

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

Cycle: _____

Evaluation Date: ____/____/____
(mm/dd/yyyy)

Has there been any change in steroid medication(s) since the previous visit?

1 Yes 2 No (Stop here)



Enter all steroids.

Steroid	Dose and Schedule

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

Protocol # N0572

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

BASELINE

ADVERSE EVENTS/SYMPTOMS FORM

ALL ITEMS MUST BE COMPLETED

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

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)
Fatigue (asthenia, lethargy, malaise)	1 0 0 1 6 2 5 6	0 1 2 3 4
Hypertension	1 0 0 2 0 7 8 2	0 1 2 3 4
Rash/desquamation	1 0 0 1 2 4 5 7	0 1 2 3 4
Anorexia	1 0 0 0 2 6 4 6	0 1 2 3 4
Dehydration	1 0 0 1 2 1 7 4	0 1 2 3 4
Nausea	1 0 0 2 8 8 1 3	0 1 2 3 4
Vomiting	1 0 0 4 7 7 0 6	0 1 2 3 4
Taste alteration (dysgeusia)	1 0 0 1 3 9 1 1	0 1 2
Pain - Abdomen NOS	1 0 0 0 0 0 8 5	0 1 2 3 4

NORTH CENTRAL CANCER TREATMENT GROUP

PLACE LABEL HERE

Protocol # N0572

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

**PRETREATMENT
MEASUREMENT FORM
ALL ITEMS MUST BE COMPLETED**

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

Date: / /
(mm/dd/yyyy)

Primary Indicator Lesion Site Type of Assessment:

(check one)

2 CT

4 MRI

NORTH CENTRAL CANCER TREATMENT GROUP

PLACE LABEL HERE

Protocol # N0572

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

ACTIVE MONITORING
MEASUREMENT FORM
ALL ITEMS MUST BE COMPLETED

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

Cycle: ____

Date (mm/dd/yyyy)	__/__/____	
Primary Indicator Lesion Site	Type of Assessment (check one)	
	CT 2 <input type="checkbox"/>	MRI 4 <input type="checkbox"/>
CT/MRI Scan Score ① (check one)	0 <input type="checkbox"/> NED 1 <input type="checkbox"/> CR 2 <input type="checkbox"/> PR 3 <input type="checkbox"/> REGR	5 <input type="checkbox"/> STAB 6 <input type="checkbox"/> PROG 7 <input type="checkbox"/> NOT DONE
Neuro Exam Score ② (check one)	1 <input type="checkbox"/> B 2 <input type="checkbox"/> S 3 <input type="checkbox"/> W	7 <input type="checkbox"/> NOT DONE
Objective Status ③ (check one)	0 <input type="checkbox"/> NED 1 <input type="checkbox"/> CR 2 <input type="checkbox"/> PR 3 <input type="checkbox"/> REGR	5 <input type="checkbox"/> STAB 6 <input type="checkbox"/> PROG 8 <input type="checkbox"/> UNKN

① CT/MRI SCAN SCORE (compared to pretreatment exam)

NED = no evidence of disease
 CR = complete disappearance of all tumor
 PR = ≥50% reduction of L x W of 1^o lesions; no new lesion
 REGR = Unequivocal decrease in size of contrast enhancement or in mass effect and no new lesion
 STAB = failure to qualify for CR, PR, Regr or Prog
 PROG = ≥25% increase in L x W of any lesions or appearance of new lesion

② NEURO EXAM SCORE (compared to pretreatment exam)

B = Better: must be stable or decreasing dose of steroids
 S = Same: failure to qualify for B or W
 W = Worse: includes patients requiring increasing steroid doses to remain stable

③ OBJECTIVE STATUS CODE

(objective status has value shown in table below)

NEURO STATUS	SCAN STATUS					
	NED	CR	PR	REGR	STAB	PROG
Better						UNKN*
Same	NED	CR	PR	REGR	STAB	PROG
Worse	UNKN*					

* Set the Objective Status equal to unknown. Treat one more cycle and at the next visit evaluate according to the table below:

NEURO STATUS	SCAN STATUS					
	NED	CR	PR	REGR	STAB	PROG
Better						PROG
Same	NED	CR	PR	REGR	STAB	
Worse						

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

Protocol # N0572

EVALUATION/TREATMENT FORM
ALL ITEMS MUST BE COMPLETED

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.

Group: (check one) 1 Phase I 3 Phase II surgical
2 Phase II nonsurgical 4 Phase II prior anti-VEGF treatments

Cycle: 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)

BSA(m^2): (used for this cycle)

Was this cycle of treatment held? 1 Yes 2 No

Primary Reason: (check one)

- 45 Dermatology/skin 146 Hypertension
38 Other nonhematologic adverse event 35 Hematologic
154 Metabolic/Laboratory 99 Other (not per protocol)

Table with 3 columns: Agent, Sorafenib (439006), and Temsirolimus (CCI779). Rows include Agent Start Date, Dose Level, Total Dose, Was DOSE LEVEL adjusted, PRIMARY REASON for Dose Adjustment, and Phase I patients only toxicity.

Cycle 1 Group 2 (Phase II Surgical) Only:

Date of final presurgery dose of Sorafenib: (mm/dd/yyyy)

Date of final presurgery dose of CCI779: (mm/dd/yyyy)

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

Protocol # N0572

**NADIR/ADVERSE EVENT LOG
ALL ITEMS MUST BE COMPLETED**

Patient ID # _____ Initials: _____ L F M

Local ID # _____ Institution _____

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

Nadirs/Adverse Events associated with treatment cycle: _____

Evaluation Date: / /
(mm/dd/yyyy)

Test	Date of Nadir (Date of lab test) (mm/dd/yyyy)	Nadir Value (The nadir is the lowest value of counts occurring between two treatments. If the only count available is taken the day of retreatment, use that value as the nadir)	Is this nadir below the LLN? (check one)	Relationship to Study Medication 1 = Not related 4 = Probable 2 = Unlikely 5 = Definite 3 = Possible	AER* Check if submitted
PLT K/uL or 10 ⁹ /L	____ / ____ / ____	_____ . _____	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No → (Go to Hgb)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	1 <input type="checkbox"/>
Hgb g/dL	____ / ____ / ____	_____ . _____	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No → (Go to ANC)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	1 <input type="checkbox"/>
ANC K/uL or 10 ⁹ /L	____ / ____ / ____	_____ . _____	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No → (Go to Adverse Event)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	1 <input type="checkbox"/>

Adverse Event CTCAE v. 3.0	MedDRA Code v. 6.0 (must be completed)	Grade (highest grade this cycle)	Relationship to Study Medication If Grade > 0 1 = Not related 2 = Unlikely 3 = Possible 4 = Probable 5 = Definite	AER* Check if submitted
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Adverse Events (stop here) GRADE ALL ADVERSE EVENTS BELOW		INCLUDE GRADE 0's		

Required Adverse Events from Section 10.0 of Protocol

Fatigue (asthenia, lethargy, malaise)	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 6 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	1 <input type="checkbox"/>
Hypertension	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 0 <input type="checkbox"/> 2 <input type="checkbox"/> 0 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 2	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 (death)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	1 <input type="checkbox"/>
Rash/desquamation	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 7	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 (death)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	1 <input type="checkbox"/>
Anorexia	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 0 <input type="checkbox"/> 0 <input type="checkbox"/> 2 <input type="checkbox"/> 6 <input type="checkbox"/> 4 <input type="checkbox"/> 6	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 (death)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	1 <input type="checkbox"/>
Dehydration	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 7 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 (death)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	1 <input type="checkbox"/>

* See Section 10.0 of the protocol.

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

Protocol # N0572

**NADIR/ADVERSE EVENT LOG
ALL ITEMS MUST BE COMPLETED**

Patient ID # _____ Initials: _____

Local ID # _____ Institution _____

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
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"/>
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"/>
Taste alteration (dysgeusia)	1 0 0 1 3 9 1 1	0 1 2	1 2 3 4 5	1 <input type="checkbox"/>
Pain - Abdomen NOS	1 0 0 0 0 0 8 5	0 1 2 3 4	1 2 3 4 5	1 <input type="checkbox"/>
Infection with unknown ANC - Abdomen NOS	9 0 0 3 0 3 5 2	0 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 1 & 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"/>	1 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"/>	1 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"/>	1 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"/>	1 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"/>	1 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"/>	1 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"/>	1 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"/>	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.

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

Protocol # N0572

**ACTIVE MONITORING
LIPID PANEL FORM
ALL ITEMS MUST BE COMPLETED**

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

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

Enter one form per time point.

Cycle: _____ Week (Time point): _____ *E.g. Enter week 1, 2, 3, or 4 during cycle 1, or every second week for cycles >1 (e.g. 1 or 3; 2 or 4).*

(Section 4 of protocol.)

Date of Lipid Panel: ____/____/____
(mm/dd/yyyy)

TESTS	UNITS	VALUE
Fasting Cholesterol	mg/dL	
Fasting Triglycerides	mg/dL	

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

Protocol # N0572

CTEP REPORT VARIABLES

PRIOR THERAPY

ALL ITEMS MUST BE COMPLETED

Patient ID # _____ Initials: _____

Local ID # _____ Institution _____ L F M

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

Please indicate all prior cancer treatment the patient has received. More than one therapy may be included. Multi-modality treatment should be listed separately (e.g. mastectomy followed by tamoxifen-code as surgery and hormonal therapy).

Check all that apply.

- No prior therapy [10052052]
- Chemotherapy single agent systemic [10008456]
- Chemotherapy multi-agent systemic [10008452]
- Chemotherapy Not Otherwise Specified (NOS) [10050693]
- Chemotherapy non-cytotoxic [90003014]
- Immunotherapy (e.g. interleukin-2, interferon) [90003006]
- Hormonal Therapy (e.g. tamoxifen, androgen deprivation) [10042027]
- Surgery [10030858]
- Radiotherapy (NOS) [10037794]
- Bone Marrow Transplant [10005990]
- Prior therapy (NOS) [90003010]
- Gene transfer [90003004]
- Anti-retroviral Therapy [90003000]
- Antisense [90003002]
- Oncolytic Virotherapy [90003008]
- Vaccine [10036903]
- Therapy NOS [90003012]

of prior chemotherapy regimens: ____

MedDRA code for primary tumor site: Glioblastoma multiforme [10018337]

Assigned Treatment Arm: (check one)

- | | | |
|-----------------------------|------------------------------|----------------------------|
| <input type="checkbox"/> A1 | <input type="checkbox"/> A6 | <input type="checkbox"/> B |
| <input type="checkbox"/> A2 | <input type="checkbox"/> A7 | <input type="checkbox"/> C |
| <input type="checkbox"/> A3 | <input type="checkbox"/> A8 | <input type="checkbox"/> D |
| <input type="checkbox"/> A4 | <input type="checkbox"/> A9 | |
| <input type="checkbox"/> A5 | <input type="checkbox"/> A10 | |

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

Protocol # N0572

END OF ACTIVE TREATMENT
ALL ITEMS MUST BE COMPLETED
Submit Once Per Patient

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

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

Date of last treatment dose on this study: ___/___/___
(mm/dd/yyyy)

Date decision was made to end active treatment: ___/___/___
(mm/dd/yyyy)

This patient will now go to: (check one) 2 Event monitoring (Complete Event Monitoring Form.)
(See Schema and Section 13.0 of the protocol)

PRIMARY REASON (check one)	COMMENTS
1 <input type="checkbox"/> Completed Treatment Per Protocol	
2 <input type="checkbox"/> Refused Further Treatment	Specify:
3 <input type="checkbox"/> Adverse Event	Specify:
4 <input type="checkbox"/> Disease Progression*	
5 <input type="checkbox"/> Alternative Treatment	Specify:
6 <input type="checkbox"/> Other Medical Problems	Specify:
7 <input type="checkbox"/> Died On Study	
9 <input type="checkbox"/> New Primary Cancer	
8 <input type="checkbox"/> Other	Specify:

* Submit documentation to verify progression. See Section 11.0 and Section 18.0 of protocol.

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

Protocol # N0572

EVENT MONITORING FORM
(Progression/Recurrence, Follow-up, New Primary, Death)
ALL ITEMS MUST BE COMPLETED

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

page 1 of 2

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
(mm/dd/yyyy)

VITAL STATUS

1 Alive } Date last known alive or death: ___/___/___
2 Dead } (mm/dd/yyyy)

Cause of death → 1 This cancer 4 Adverse Event 2 Other, specify _____
(related to treatment)

DISEASE FOLLOW-UP STATUS

Has the patient been assessed by a physician 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: ___/___/___
(mm/dd/yyyy)

NOTICE OF FIRST RELAPSE/PROGRESSION

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

2 No 1 Yes. If Yes, Date of Relapse/Progression:** ___/___/___
(mm/dd/yyyy)

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: ___/___/___
(mm/dd/yyyy)

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 page 2 of the Event Monitoring 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 PD.

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

Protocol # N0572

EVENT MONITORING FORM
(LATE ADVERSE EVENT REPORTING)
ALL ITEMS MUST BE COMPLETED

Patient ID # _____ Initials: _____
L F M
Local ID # _____ Institution _____

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

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 <i>(must be completed)</i>	Highest Grade	Relationship to Study Medication 1 = Not related 2 = Unlikely 3 = Possible 4 = Probable 5 = Definite	Late Adverse Event Start Date <i>(mm/dd/yyyy)</i>
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"/>	1 2 3 4 5 (death)	1 2 3 4 5	_ / _ / _ _ _
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"/>	1 2 3 4 5 (death)	1 2 3 4 5	_ / _ / _ _ _
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"/>	1 2 3 4 5 (death)	1 2 3 4 5	_ / _ / _ _ _
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"/>	1 2 3 4 5 (death)	1 2 3 4 5	_ / _ / _ _ _
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"/>	1 2 3 4 5 (death)	1 2 3 4 5	_ / _ / _ _ _
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"/>	1 2 3 4 5 (death)	1 2 3 4 5	_ / _ / _ _ _
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"/>	1 2 3 4 5 (death)	1 2 3 4 5	_ / _ / _ _ _
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"/>	1 2 3 4 5 (death)	1 2 3 4 5	_ / _ / _ _ _
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"/>	1 2 3 4 5 (death)	1 2 3 4 5	_ / _ / _ _ _
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"/>	1 2 3 4 5 (death)	1 2 3 4 5	_ / _ / _ _ _
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"/>	1 2 3 4 5 (death)	1 2 3 4 5	_ / _ / _ _ _
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"/>	1 2 3 4 5 (death)	1 2 3 4 5	_ / _ / _ _ _

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP
PATHOLOGY REPORTING FORM
BRAIN TUMOR

I. Data Manager

Protocol # N0572

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

Primary Pathologist: _____ No. of slides sent: _____

Clinic/Hospital: _____ Date sent: _____

Reviewer: _____ Slide No. _____ Sequence No. _____

THIS REPORT IS FOR: (check one) 1 Primary 2 Recurrent

1. DATE OF OPERATIVE PROCEDURE

____/____/____
(mm/dd/yyyy)

II. Information obtained from pathology report

2. RADIATION EFFECTS (If prior radiation)

1. Yes 2. No

3. MICROSCOPIC FEATURE OF PRIMARY NEOPLASM (0=Absent, 1=Present, 9=Uncertain)

Nuclear abnormalities (atypia, pleomorphism) Mitoses Endothelial proliferation Necrosis

4. HISTOLOGIC SUBTYPE (For mixed tumors, specify by prevalence)
(number all that apply):

Oligodendroglioma Astrocytoma, fibrillary Astrocytoma, NOS (describe in comments)
 Astrocytoma, pilocytic Astrocytoma, gemistocytic Gliosarcoma
 Astrocytoma, microcystic (cerebellar type) Astrocytoma, giant cell
 Astrocytoma, protoplasmic Astrocytoma, small cell (undifferentiated)

5. HISTOLOGIC GRADE OF PRIMARY NEOPLASM (Degree of differentiation)
(check one)

1 Grade I 2 Grade II 3 Grade III 4 Grade IV

COMMENTS: _____

FOR PATIENTS WITH REBIOPSY AFTER RADIATION
(Please complete the following items after rebiopsy)

6. MICROSCOPIC FEATURES OF RADIATION EFFECT (0=Absent, 1=Present, 9=Uncertain)

Vascular Changes:

Proliferation
 Necrosis, thrombosis, sclerosis

Tissue Changes:

Atrophy/Gliosis
 Necrosis

Other (specify) _____

COMMENTS: _____

III. Signatures

Reviewer

Date

1. Agree with diagnosis
 2. Minor disagreement
 3. Substantial disagreement

Comments: _____

Research Base Advisor

Date

1. Agree with diagnosis
 2. Minor disagreement
 3. Substantial disagreement

Comments: _____

Committee Chairman

Date

1. Agree with diagnosis
 2. Minor disagreement
 3. Substantial disagreement

Comments: _____

Block/Slide number(s) to be used for research/banking: _____

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

PATHOLOGY SUBMISSION FORM

(NOTE: This form is used to update the Outstanding Materials Report)

Protocol Number: N0572

Patient ID: _____ Patient Initials: _____

L F M

Institution Number: _____

Institution: _____

**** This form must be submitted to the NCCTG Operations Office at the time slides/blocks are sent to the NCCTG reviewer (see Pathology section of the protocol) ****

Date specimen shipped: (mm/dd/yyyy) ___/___/____

Reviewer: Dr. Bernd Scheithauer or one of his colleague neuropathologists, Mayo Clinic Rochester - Rochester, MN

Number of slides sent: ___

Accession numbers on the slides sent:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Number of blocks sent: ___

Accession numbers on the blocks sent:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Comments:

Institution Contact Information: (Please Print)
CRA/Nurse Contact: _____
Institution Name: _____
Street Address: _____
City: _____
State: _____ Zip: _____
Phone Number: _____
Fax Number: _____
E-mail Address: _____

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

ACTIVE MONITORING
CYCLE 1

TISSUE SPECIMEN SUBMISSION FORM
ALL ITEMS MUST BE COMPLETED

Protocol # N0572

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

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

Cycle: 1

INSTRUCTIONS

Complete this form *for all patients* and enter into the remote data entry system within 7 days of tissue collection. See Section 17 of the protocol for specimen requirements and shipment.

Is this a Phase II surgical patient? 1 Yes 2 No → End form.



Were paraffin embedded tissue obtained?

1 Yes Date of biopsy: ___/___/___
(mm/dd/yyyy)

2 No Reason: _____

Was a frozen tissue specimen obtained? 1 Yes 2 No

PLACE LABEL HERE

ACTIVE MONITORING
NON SURGICAL PATIENTS
BLOOD SPECIMEN SUBMISSION FORM
CYCLE 1 DAY 1
ALL ITEMS MUST BE COMPLETED

Protocol # N0572

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

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

Cycle: 1

INSTRUCTIONS

Complete this form **for all non surgical patients** and enter into the remote data entry system within 7 days of specimen collection. See Section 14 of the protocol for specimen requirements and shipment.

Was a research blood specimen collected?

1 Yes Date of collection: ___/___/___
(mm/dd/yyyy)

2 No Reason: _____

**MOLECULAR TARGETED COMBINATIONS CORRELATIVE (MTC2) STUDIES
SPECIMEN TRANSMITTAL FORM (PAGE 2/2)**

SPECIMEN PROCESSING INFORMATION

*** This page to be completed by submitting institution ***

Patient Initials (L, F): _____ Date of Birth: _____ Protocol #: _____
mm/dd/yy
Patient Clinical Study # _____
BPC # _____

SPECIMEN PROCESSING METHOD

	OCT Frozen	Snap-Frozen	Fixed and Paraffin Embedded	Formalin Fixed	Other (specify)
Tumor Tissue					
	EDTA (Lavendar Top)	(Red Top)	Heparin (Green Top)	Other (specify)	
Whole Blood					
Plasma					
Serum					

SPECIMEN PROCESSING TIME (From Acquisition to Freezing/Fixation)

Optimal time should be less than 1 hour; however it is important to provide the actual time to assist with interpreting results

	< 1 hour	1-2 hours	2-4 hours	> 4 hours	NA
Tumor Tissue					
Whole Blood					
Plasma					
Serum					
Other (specify):					

STORAGE TYPE AND DURATION

	Room temperature (and Duration)	Refrigerator (and Duration)	Standard non-cycling freezer (and Duration)	Ultracold freezer/liquid Nitrogen/dry ice (and Duration)	Other, specify type and duration in storage
Tumor Tissue					
Whole Blood					
Plasma					
Serum					
Other (specify):					

PLACE LABEL HERE

NORTH CENTRAL CANCER TREATMENT GROUP

Protocol # N0572

Patient ID # _____ Initials: _____

L F M

Local ID # _____ Institution _____

NOTIFICATION FORM

Grade 4 or 5 Non-AER Reportable Events/Hospitalization

ALL ITEMS MUST BE COMPLETED

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

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 submit this form.
- Fill out all information known.
- Fax to the North Central Cancer Treatment Group Operations Office within 5 working days of notification (507-284-9628).
- These events must also be reported on the Nadir/Adverse Event Form.

Date membership CRA aware of event(s):

Person Completing/Submitting Form:

____/____/____
(mm/dd/yyyy)

Name: _____

Phone #: (____) _____ - _____

Cycle #: _____ Arm: _____

Event ≥ Grade 4

2 No 1 Yes

Date of First Occurrence (mm/dd/yyyy)	Event Type (only one event per line)	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

2 No 1 Yes → Date of Admission: ____/____/____
(mm/dd/yyyy)

Reason(s) for Hospitalization:

1 Adverse Event, specify type and grade _____

2 Prophylactic, specify _____

3 Other, specify _____

Biospecimen Accessioning Processing
Fax Supply Order Form – No Cover Sheet Necessary
Fax to Research Kit Building @ 507-538-4103

NOTE: Form must be either typed or printed legibly and filled out completely.

Study ID: N0572

Investigator: _____

Order Placed By: _____ Phone #: () _____

Email: _____ Fax #: () _____

Complete Address (kits sent to):

ALLOW AT LEAST TWO WEEKS TO RECEIVE THE KITS.

NOTE: Kits will be sent via FedEx® Ground at no additional cost to the participating institutions. Kits will not be sent via rush delivery service unless the participating institution provides their own FedEx® account number or alternate billing number for express service. **The study will not cover the cost for rush delivery of kits.**

Date Needed: _____
(Please be specific)

Fed Ex account number (Rush deliveries only) _____

<u>Type of Kits</u>	<u># of Kits Needed</u>
N0572 Custom Research Blood Kit _____	_____
_____	_____
Total Kits	_____

Questions? Contact the Biospecimen Resource Manager listed on the Protocol Resource page of the protocol.