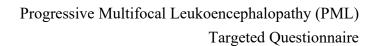


1. Reporter Details						□Initial □Follow-u			w-up			
Reporter Name:					E-mail	E-mail:						
Contact address:						Teleph	Telephone number:					
					Fax nu	Fax number:						
Тур	e:	□ Physician (Specialty):				□ Con	sumer	or other	non healthcare	professio	onal	
	☐ Pharmacist				☐ Oth	☐ Other (Specify)						
If reporter is a consumer, have they informed their physician of the					the expos	ne exposure?			Yes			
Has the consumer provided permission to contact their healthcare					re profess	professional?						
If yes, please provide healthcare professional contact details:												
Nan	ne:			Type:				Telephone:				
Add	lress:								Email:			
2. P	atient I						TT .	1 .		77		
		Date of birth (Day/Month/Year)		Age			Heig			Weight		
		(Duy/menus 1 eus)		Yrs/mo.			cm			kg		
					•							
3. C	ompan	y Drug Section	Γ		T _			T _		T	T _	Τ = .
		Name	Strengt	h Dose	Rout	e In	star		tment	Treatment	Lot	Expiry
									onth/year)	end date (day/month/year)		
1.												
2.												
3.												
4 D	etaila a	f Advance Event										
	etans o erse Ev	f Adverse Event		Start Date	Sto	p Date	e Out	come				
114,	CISC EV			Start Date Stop Date			☐ Recovered / Resolved					
							☐ Recovered / Resolved With Sequelae					
							☐ Recovering /Resolving ☐ Not Recovered /Not Resolved					
							☐ Fatal					
								Inknown				
5. Medical History												
	dical His							BD Histo				
(Enter all treatments below)						Specify Type Date of Diagnosis						
					Therapies Received							
							MalignancySpecify Type					
						Date of Diagnosis						
					■ In	■ Immune Deficiency						
						Human Immunodeficiency Virus (+/-) If (+), Date of Diagnosis						





	If (+), CD4 Count (at time of PML diagnosis)						
	 Ongoing graft-versus-host disease (Yes/No) 						
Prior Treatments for IBD:	 Long-term immunosupression (ie. greater than 8 weeks) (Yes/No) Include medications, dose, route, frequency, start/stop dates for each medication/treatment received. 						
	dates for each medication/freatment received.						
Prior Treatments for Other Important Past Medical History Conditions:							
6. PML Disease							
Signs and Symptoms of PML (include onset date(s) for each sign and symptoms)							
Neurology Examinations (include date examination was conducted and results of exam	• • •						
Neurology Examinations (include date examination was conducted and results of exam	nination)						
Brain MRI / Brain Imaging Studies (include date of MRI and MRI results, types and results of other brain imaging studies)							
Lumbar Puncture Results (document all lumbar punctures, especially date of lumbar punctures)	nuncture of the first JCV DNA (+) cerebrospinal fluid (CSF) result)						
Brain Biopsy (include date of brain biopsy, highlights of brain biopsy pathology report, e	poidence of ICV on immunohistochemistry or FISH staining)						
Brain Bropsy (include date of brain biopsy, nightights of brain biopsy pathology report, e	evidence of 3C+ on immunonistochemistry of F1311 staining)						

7. Labs						
	Date (day/month/year)	Results	Normal Range			
White Blood Cell Count	, , ,					
White Blood Cell Count Differential						
Hemoglobin						
Hematocrit						
Platelet Count						
Other						
JCV Antibody Status						



Progressive Multifocal Leukoencephalopathy (PML) Targeted Questionnaire

JCV DNA (non-CSF sources								
for JCV testing)								
8. PML Diagnosis and Treati	ment							
Date of PML Diagnosis (day/month/year)		na Exchange (P		Other PML Treatments (include type of				
		ınoadsorption (IA)	treatment(s), dose, route, frequency, start/stop dates for each treatment received)				
Date of Permanent Discontinuation	n of □ PL	EX		for each treatment received)				
Teriflunomide Treatment (day/mont	th/waar) LIA	_						
Termunomide Treatment (day/mon	Dates	of treatment:						
		ber of cycles:						
9. Follow-Up								
Any treatments for underlying dis	ease post-PML o	liagnosis:	□ Yes □ No					
If yes, specify:								
PML Outcome:								
Event of PML continuing: □ Yes	□ No							
Current clinical status of patient:								
Outcome of the event:								
□ Recovered / Resolved □ Recovered / Resolved With Sequelae □ Recovering / Resolving □ Not Recovered / Not Resolved								
☐ Fatal ☐ Unknown		-						
If PML resulted in fatal outcome,	provide date of	death (day/month/	year):					
Cause of death:								
Autopsy conducted (and report available): □ Yes □ No								
10. Completed By								
Name:		gnature:		Date (day/month/year):				
		~						