ASTCT Cellular Therapy RFI 2025: Program Information

ASTCT American Society for Transplantation and Cellular Therapy

Part A: General Information

Provide the legal name and address of the institution or corporation responsible for the provision of transplant services.

Name: _____

Name used when submitting data to CIBMTR: _____

Street Address: _____

City: _____

State: _____ **Zip**: _____

Hospital Tax ID Number: _____

Program Clinical Director Email:

Program Administrator Director Email:

A-1. Is your institution affiliated with or the parent corporation of other hospitals/institutions? Yes ☐ No ☐

If yes, what is the name(s) of the affiliated institutions and the nature of the relationship?

A-2. Are there cellular therapy-associated clinical services (evaluation, major diagnostic testing, cell collection/apheresis, etc.) being provided at the affiliated institutions listed in question A1? Yes ☐ No ☐

If yes, please list which affiliate and which type of service.

A-3. Current FACT Program Accreditation / Certification*

FACT – Clinical Program								
Adult Autologous	Yes ☐	No ☐	_____	or	Yes ☐	No ☐	_____
Adult Allogeneic	Yes ☐	No ☐	_____	or	Yes ☐	No ☐	_____
Pediatric Autologous	Yes ☐	No ☐	_____	or	Yes ☐	No ☐	_____
Pediatric Allogeneic	Yes ☐	No ☐	_____	or	Yes ☐	No ☐	_____
FACT – Collection Program	Yes ☐	No ☐	_____	or	Yes ☐	No ☐	_____
FACT – Cell Processing Program	Yes ☐	No ☐	_____	or	Yes ☐	No ☐	_____
FACT – Immune Effector Cell Program	Yes ☐	No ☐	_____	or	Yes ☐	No ☐	_____

***NOTE:** ASTCT does not warrant, guarantee, or endorse every accreditation/certification program listed above, and transplant centers need not obtain accreditation/certification from every program listed. Payers individually establish requirements for inclusion of transplant centers in their networks.

A-4. Number of CAR-T administrations performed with FDA-approved products, by patient age

Record the total number of administrations performed in the years indicated. Note: Please INCLUDE FDA-approved products given via an Expanded Access/Managed Access Protocol. Do not include individual Investigational New Drug (IND) or other clinical trial administrations in this table.

Calendar Year	Age 0-10	Age 11-17	Age 18-64	Age 65+
2021				
2022				
2023				
2024				
Total				

A-5. Number of CAR-T administrations performed with FDA-approved products, by product, 2021-2024 (through 9/30/2024)

Record the total number of administrations performed in the years indicated. Note: Please INCLUDE FDA-approved products given via an Expanded Access/Managed Access Protocol. Do not include individual Investigational New Drug (IND) or other clinical trial administrations in this table.

	Total	90-day survival	
Product	**# patients infused**	**# patients**	**%**
Idecabtagene Vicleucel			
Obecabtagene Autoleucel			
Lisocabtagene Maraleucel			
Ciltacabtagene Autoleucel			
Tisagenleclucel			
Brexucabtagene Autoleucel			
Axicabtagene Ciloleucel			
Total			

A-6. Number of CAR-T administrations performed with clinical trial or research protocol products, by patient age

ASTCT Cellular Therapy RFI 2025: Program Information

Record the total number of administrations performed in the years indicated. Patients with multiple administration events will be counted more than once, multiple administrations within one event (i.e. split dosing) will be counted once. Include Individual IND administrations.

Calendar Year	Age 0-10	Age 11-17	Age 18-64	Age 65+
2021				
2022				
2023				
2024				
Total				

A-7. Has the Program been closed or suspended for any reason during the past 36 months?

Yes ☐ No ☐

If yes, provide dates and explain:

A-8. How does the Program provide the following cell therapy-related services?

Apheresis	☐ inpatient	☐ outpatient	☐ both
Lymphodepleting Regimens	☐ inpatient	☐ outpatient	☐ both
Cell Therapy Infusion	☐ inpatient	☐ outpatient	☐ both
Post-infusion Care	☐ inpatient	☐ outpatient	☐ both

A-9. Indications for which FDA-approved CAR-T therapies are administered in the Program:

☐ Acute lymphoblastic leukemia – adult
☐ Acute lymphoblastic leukemia – pediatric
☐ Diffuse large B-cell lymphoma/Primary mediastinal B-cell lymphoma/Transformed lymphoma
☐ Follicular lymphoma
☐ Mantle cell lymphoma
☐ Multiple myeloma

A-10. Manufacturers with which the Program is currently (at the time of RFI completion) certified for FDA-approved CAR-T therapies:

☐ Bristol Myers Squibb
☐ J&J/Janssen/Legend
☐ Kite Pharma/Gilead
☐ Novartis
☐ Autolus
☐ Other: _____

ASTCT Cellular Therapy RFI 2025: Program Information

B-1. Are all patients managed under a protocol (either research or institutional standard of care)? Yes ☐ No ☐

If treatments are performed "off protocol", how is the decision made?

B-2. Does the Program report CAR-T data to the CIBMTR? Yes ☐ No ☐

Part C: Cellular Therapy Team

Name	Board Certification / Specialty	Years of experience actively managing cellular therapy patients	Became a member of this team Month/Year
Adult Program Clinical Director:			
Adult Program Administrative Director:			
Adult Treating Physician(s):			
Pediatric Program Clinical Director:			
Pediatric Program Administrative Director:			
Pediatric Treating Physician(s):			
IECT Coordinator:			

Part D: Summary Information

D-1. Describe the Program's unique qualities.

D-2. Provide any additional information that you feel is important regarding the Program.

I certify that the information contained in this survey and all attachments is accurate, complete, and true. I understand that submission of this survey does not automatically result in participation or continued participation.

Name _____ Signature _____

Title Program Administrative Director Date _____

Name _____ Signature _____

Title Program Clinical Director Date _____