

## YESCARTA<sup>®</sup> REMS Program Knowledge Assessment

To become an authorized representative for your hospital and its associated clinics in the YESCARTA<sup>®</sup> REMS Program, you will need to answer all questions below correctly. All other REMS-trained staff must also answer all questions correctly.

Responses to the YESCARTA<sup>®</sup> REMS Program Knowledge Assessment questions and the YESCARTA<sup>®</sup> REMS Program Hospital Enrollment Form must be emailed to [YESCARTAREMS@kitepharma.com](mailto:YESCARTAREMS@kitepharma.com) or faxed to **1-310-496-0397**.

### Questions

1. What is the approved indication for YESCARTA<sup>®</sup>?
  - A. Patients with relapsing multiple sclerosis
  - B. Patients with lung cancer
  - C. Patients with bladder cancer
  - D. Adult patients with relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, and DLBCL arising from follicular lymphoma.
2. Prior to discharge, a YESCARTA<sup>®</sup> Patient Wallet Card must be given to patients who have been infused with YESCARTA<sup>®</sup>.  
True \_\_\_ False \_\_\_
3. Every certified hospital and its associated clinics are required to have immediate access to a minimum of 2 doses of tocilizumab on-site for each patient and available for administration, for treatment of CRS, within 2 hours of YESCARTA<sup>®</sup> infusion.  
True \_\_\_ False \_\_\_
4. After YESCARTA<sup>®</sup> infusion, patients should be advised to:
  - A. Refrain from driving or operating heavy or potentially dangerous machinery after YESCARTA<sup>®</sup> administration until at least 8 weeks after infusion
  - B. Remain within close proximity (within 2 hours) of the certified treating hospital and its associated clinics for at least 4 weeks following infusion
  - C. Seek immediate attention if they experience signs and symptoms of CRS and/or neurologic toxicities
  - D. All of the above
5. Which of the following is true regarding the time to onset of CRS? It typically occurs:
  - A. With a median time to onset of 7 days
  - B. With a median time to onset of 5 days
  - C. With a median time to onset of 2 days
  - D. Rarely starts during the first week following YESCARTA<sup>®</sup> infusion

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6. All of the following regarding neurologic toxicity related to YESCARTA<sup>®</sup> are correct **except**:
- A. Neurologic toxicity always occurs concurrently with CRS
  - B. Continuous cardiac telemetry and pulse oximetry are recommended for Grade 2 or higher neurologic toxicity
  - C. The median time to onset of neurologic toxicity is 4 days
  - D. The most common signs or symptoms of neurologic toxicity include encephalopathy, headache, tremor, dizziness, aphasia, delirium, insomnia, and anxiety
7. Four days after infusion with YESCARTA<sup>®</sup>, a 49-year-old woman with relapsed diffuse large B-cell lymphoma (DLBCL) fully recovers from a Grade 3 CRS that started the day after infusion of YESCARTA<sup>®</sup>. The next day, she develops a Grade 2 dysphasia. She has no signs or symptoms of CRS. Appropriate management for this patient would include (please select single best answer):
- A. Consider nonsedating, antiseizure medicines (eg, levetiracetam) for seizure prophylaxis
  - B. Start tocilizumab 8 mg/kg intravenously over 1 hour (not to exceed 800 mg)
  - C. Start dexamethasone 10 mg intravenously every 6 hours
  - D. A and C
8. One day after infusion of YESCARTA<sup>®</sup>, a 60-year-old man with relapsed diffuse large B-cell lymphoma (DLBCL) develops the following signs and symptoms of CRS: high fever (39°C-40°C), hypoxia requiring <40% FiO<sub>2</sub>, and hypotension requiring intravenous fluids. This patient's CRS grade would be most consistent with:
- A. Grade 1 CRS
  - B. Grade 2 CRS
  - C. Grade 3 CRS
  - D. Grade 4 CRS

**Please Complete All Fields Below**

\_\_\_\_\_  
Name \_\_\_\_\_  
Title

Credentials  DO  MD  RPh  RN/NP  PA Other \_\_\_\_\_

I am the authorized representative  Yes  No

\_\_\_\_\_  
Hospital/Associated Clinic Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State ZIP Code

\_\_\_\_\_  
Signature Date