



## YESCARTA and TECARTUS REMS Program Knowledge Assessment

To become an authorized representative for your hospital and its associated clinics in the YESCARTA and TECARTUS 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 and TECARTUS REMS Program Knowledge Assessment questions and the YESCARTA and TECARTUS REMS Hospital Enrollment Form must be emailed to [YTREMS@kitepharma.com](mailto:YTREMS@kitepharma.com) or faxed to **1-310-496-0397** or completed online at [www.KiteREMSTraining.com](http://www.KiteREMSTraining.com).

### Questions

1. Prior to discharge, a YESCARTA and TECARTUS REMS Patient Wallet Card must be given to patients or the caregiver of those patients who have been infused with YESCARTA or TECARTUS.  
True \_\_\_\_\_ False \_\_\_\_\_
2. 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 cytokine release syndrome (CRS), within 2 hours of YESCARTA or TECARTUS infusion.  
True \_\_\_\_\_ False \_\_\_\_\_
3. After YESCARTA or TECARTUS infusion, patients should be advised to:
  - A. Refrain from driving or operating heavy or potentially dangerous machinery for at least 8 weeks after YESCARTA or TECARTUS 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 neurological toxicities
  - D. All of the above
4. Which of the following is true regarding the time to onset of CRS? (select one)
  - A. Median time to onset of CRS following YESCARTA infusion is 2-5 days
  - B. Median time to onset of CRS following TECARTUS infusion is 3-5 days
  - C. CRS rarely starts during the first week following YESCARTA or TECARTUS infusion
  - D. A & B
5. Which of the following is true regarding the time to onset of neurotoxicity? (select one)
  - A. Median time to onset of neurotoxicity following YESCARTA infusion is 4-6 days
  - B. Neurotoxicity rarely starts during the first week following YESCARTA or TECARTUS infusion
  - C. Median time to onset of neurotoxicity following TECARTUS infusion is 6-7 days
  - D. A & C

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6. All of the following regarding neurologic toxicity related to YESCARTA or TECARTUS 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 4-6 days for patients with LBCL and 6 days for patients with iNHL following YESCARTA infusion
  - D. The median time to onset of neurologic toxicity is 6 days for patients with MCL and 7 days for patients with ALL following TECARTUS infusion
7. Four days after infusion with YESCARTA, 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. The next day, she develops a Grade 2 dysphasia. She has no signs or symptoms of CRS. Per the REMS Program Training, appropriate management for this patient would include (please select single best answer):
- A. Consider 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 four times a day
  - D. A and C
8. One day after infusion of TECARTUS, a 60-year-old man with mantle cell lymphoma (MCL) develops the following signs and symptoms of CRS: high fever (39-40°C), hypoxia requiring <40% FiO<sub>2</sub>, and hypotension requiring intravenous fluids. According to the modified Lee Grading Scale as defined in the REMS Program Training, 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 \_\_\_\_\_

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

\_\_\_\_\_  
Address

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

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