Site Number:

Patient Number:

Enrollment

Date of Contact

[Revision: Initial revision of study]

(Visit ID = 10 / Visit Display Name = Enrollment / Visit Abbrev = ENROLL / PageID = 10 / Page Display Name = Date of Contact / Description = Date of Contact)

* Date of Contact		(DD-MMM-YYYY)
* Reporter of Information	○ Patient ○ Obstetrician ○ Neurologist ○ Other	
* Reporter of Information	○ Patient ○ Obstetrician ○ Neurologist ○ Infant HCP ○ Other	
* Other, specify		

Page 5

Eligibility and Informed Consent

[Revision: Initial revision of study]

(Visit ID = 10 / Visit Display Name = Enrollment / Visit Abbrev = ENROLL / PageID = 20 / Page Display Name = Eligibility and Informed Consent / Description = Eligibility and Informed Consent)

ELIGIBILITY		
* Confirm that the patient is currently pregnant	○ No ○ Yes	
* Is the patient eligible to participate in this registry as per protocol inclusion/exclusion criteria?	○ No ○ Yes	
If Yes, which study enrollment group?		
Ocrelizumab exposed	☐	
* Start date of last dose prior to the LMP (last menstrual period):		(UNK-UNK-UNK)
* Stop date of last dose prior to LMP (last menstrual period):		(UNK-UNK-UNK)
To enroll in the internal comparator, a patient has documentation of either of the following: *(1) The patient was not exposed to any DMTs during the 6 months prior to their LMP or at any time during their pregnancy , or* *(2) The patient was exposed to glatiramer acetate during the 6 months prior to their LMP up through the first trimester only.*		
Not DMT exposed	☐	
Glatiramer-acetate exposed	☐	
INFORMED CONSENT		
* Informed consent collected from patient?	○ No ○ Yes	
* Date of informed consent		(DD-MMM-YYYY)
* Protocol version	○ Original Protocol	
* ICF version	○ Original Protocol	
* Was re-consent provided by the patient?	○ No	

○ Yes

Page 6

If Yes, please complete the Re-Consent Form.

Re-Consent

[Revision: Initial revision of study]

(Visit ID = 10 / Visit Display Name = Enrollment / Visit Abbrev = ENROLL / PageID = 30 (*) / Page Display Name = Re-Consent / Description = Re-Consent)

Sequence number		
* Re-consent date (Patient's Signature date)		(DD-MMM-YYYY)
* Protocol version to which this re-consent corresponds	○ Original Protocol	
* ICF version	○ Original Protocol	

Demographics & Characteristics

[Revision: Initial revision of study]

(Visit ID = 10 / Visit Display Name = Enrollment / Visit Abbrev = ENROLL / PageID = 40 / Page Display Name = Demographics & Characteristics / Description = Demographics & Characteristics)

* Maternal age (years)		(format xx)
* Maternal Date of Birth		(UNK-UNK-UNK)
* Paternal age (years)		(format xx)
* Paternal Date of Birth		(DD-MMM-YYYY)
* Ethnicity	○ Hispanic or Latino ○ Not Hispanic or Latino ○ Not Reported ○ Unknown	
Race:		
White or Caucasian	☐	
Black or African American	☐	
Native Hawaiian or Other Pacific Islander	☐	
Asian	☐	
American Indian or Alaska Native	☐	
Not Reported	☐	
Other	☐	
* Other, specify		

* Education level	○ Less than secondary ○ Secondary ○ Some post-secondary ○ Masters ○ Doctorate/professional degree ○ Other	
* Other, specify		
* Height		(format xxx.xx)
* Height unit	○ in ○ cm	
* Pre-pregnancy Weight		(format xxx.xx)
* Pre-pregnancy Weight unit	○ lb ○ kg	
* Weight		(format xxx.xx)
* Weight unit	○ lb ○ kg	
BMI	(auto calculated)	(format xxx.xx)

Medical History

[Revision: Initial revision of study]

(Visit ID = 10 / Visit Display Name = Enrollment / Visit Abbrev = ENROLL / PageID = 50 / Page Display Name = Medical History / Description = Medical History)

Has the patient been diagnosed with any of the following:

* Obesity	○	No
	○	Yes
	○	Unknown
* If Yes, resolved or current	○	Resolved
	○	Current
* Asthma	○	No
	○	Yes
	○	Unknown
* If Yes, resolved or current	○	Resolved
	○	Current
* Hypertension	○	No
	○	Yes
	○	Unknown
* If Yes, resolved or current	○	Resolved
	○	Current
* Kidney Disease	○	No
	○	Yes
	○	Unknown
* If Yes, resolved or current	○	Resolved
	○	Current
* Thyroid Disease	○	No
	○	Yes
	○	Unknown

* If Yes, resolved or current	○ Resolved ○ Current
* Clotting Disorder	○ No ○ Yes ○ Unknown
* If Yes, resolved or current	○ Resolved ○ Current
* Lupus	○ No ○ Yes ○ Unknown
* If Yes, resolved or current	○ Resolved ○ Current
* Other significant comorbidity, other than non-infectious	○ No ○ Yes ○ Unknown
* Please specify	
* If Yes, resolved or current	○ Resolved ○ Current
* Please specify	
* If Yes, resolved or current	○ Resolved ○ Current
* Please specify	
* If Yes, resolved or current	○ Resolved ○ Current
* Sexually Transmitted Diseases (STDs) & Related Conditions	○ No ○ Yes ○ Unknown

* Bacterial Vaginosis (BV)	☒	No
	○	Yes
	○	Unknown
* If Yes, resolved or current	○	Resolved
	○	Current
* Chlamydia	○	No
	○	Yes
	○	Unknown
* If Yes, resolved or current	○	Resolved
	○	Current
* Gonorrhea	○	No
	○	Yes
	○	Unknown
* If Yes, resolved or current	○	Resolved
	○	Current
* Hepatitis B	○	No
	○	Yes
	○	Unknown
* If Yes, resolved or current	○	Resolved
	○	Current
* Hepatitis C	○	No
	○	Yes
	○	Unknown
* If Yes, resolved or current	○	Resolved
	○	Current
* Herpes	○	No
	○	Yes
	○	Unknown

* If Yes, resolved or current	○ Resolved ○ Current
* HIV/AIDS	○ No ○ Yes ○ Unknown
* If Yes, resolved or current	○ Resolved ○ Current
* Human Papillomavirus (HPV)	○ No ○ Yes ○ Unknown
* If Yes, resolved or current	○ Resolved ○ Current
* Pelvic Inflammatory Disease (PID)	○ No ○ Yes ○ Unknown
* If Yes, resolved or current	○ Resolved ○ Current
* Other Sexually Transmitted Diseases	○ No ○ Yes ○ Unknown
* Please, specify:	
* If Yes, resolved or current	○ Resolved ○ Current
* Zika Virus	○ No ○ Yes ○ Unknown
* If Yes, resolved or current	○ Resolved ○ Current

* Other significant comorbidity, other than infectious	○ No ○ Yes ○ Unknown
* Please specify	
* If Yes, resolved or current	○ Resolved ○ Current
* Please specify	
* If Yes, resolved or current	○ Resolved ○ Current
* Please specify	
* If Yes, resolved or current	○ Resolved ○ Current
* Type I diabetes	○ No ○ Yes ○ Unknown
* If Yes, resolved or current	○ Resolved ○ Current
* Type II diabetes	○ No ○ Yes ○ Unknown
* If Yes, resolved or current	○ Resolved ○ Current
* Gestational diabetes	○ No ○ Yes ○ Unknown
* If Yes, resolved or current	○ Resolved ○ Current

* Nutritional deficiencies	○	No
	○	Yes
	○	Unknown
* Anemia	○	No
	○	Yes
* If Yes, resolved or current	○	Resolved
	○	Current
* Vitamin B12	○	No
	○	Yes
	○	Unknown
* If Yes, resolved or current	○	Resolved
	○	Current
* Vitamin A	○	No
	○	Yes
	○	Unknown
* If Yes, resolved or current	○	Resolved
	○	Current
* Calcium	○	No
	○	Yes
	○	Unknown
* If Yes, resolved or current	○	Resolved
	○	Current
* Other Nutritional Deficiencies	○	No
	○	Yes
	○	Unknown
* Please, specify:		
* If Yes, resolved or current	○	Resolved
	○	Current

Multiple Sclerosis Disease

[Revision: Initial revision of study]

(Visit ID = 10 / Visit Display Name = Enrollment / Visit Abbrev = ENROLL / PageID = 80 / Page Display Name = Multiple Sclerosis Disease / Description = Multiple Sclerosis Disease)

* Date of first MS symptom onset		(UNK-UNK-UNK)
* Diagnosis date		(UNK-UNK-UNK)
* Did the patient experience any relapses in the past 3 years?	○ No ○ Yes	
* If yes, total number of relapses experienced within the first year prior to the study enrollment date		(format xx)
* If yes, total number of relapses experienced within the second year prior to the study enrollment date		(format xx)
* If yes, total number of relapses experienced within the third year prior to study enrollment date		(format xx)
* Start date of relapse #1		(UNK-UNK-UNK)
* End date of relapse #1		(UNK-UNK-UNK)
* Start date of relapse #2		(UNK-UNK-UNK)
* End date of relapse #2		(UNK-UNK-UNK)
* Start date of relapse #3		(UNK-UNK-UNK)
* End date of relapse #3		(UNK-UNK-UNK)
* Start date of relapse #4		(UNK-UNK-UNK)
* End date of relapse #4		(UNK-UNK-UNK)

* Start date of relapse #5		(UNK-UNK-UNK)
* End date of relapse #5		(UNK-UNK-UNK)
* Start date of relapse #6		(UNK-UNK-UNK)
* End date of relapse #6		(UNK-UNK-UNK)
* Type of MS at the time of the first treatment	○ Relapsing Remitting MS (RRMS) ○ Secondary Progressive MS (SPMS) ○ Primary Progressive MS (PPMS) ○ Clinically Isolated Syndrome (CIS) ○ Radiologically Isolated Syndrome (RIS) ○ Unknown	
Expanded Disability Status Scale (EDSS) score available?	○ No ○ Yes	

For baseline EDSS score, use the score most proximal to enrollment date.

* Date of most recent EDSS Score		(UNK-UNK-UNK)
* Most recent EDSS score:		(format xx.x)

* If No, how would you rate the patient's disability status at the time of first ocrelizumab exposure or other MS treatment/administration?	○ Normal neurological examination ○ Minimal disability ○ Increased limitation in walking ability ○ Need for ambulatory aid ○ Restricted to wheelchair ○ Bedbound ○ Unknown	
* If No, how would you rate the patient's current disability status?	○ Normal neurological examination ○ Minimal disability ○ Increased limitation in walking ability ○ Need for ambulatory aid ○ Restricted to wheelchair ○ Bedbound ○ Unknown	
* Did the patient have a MS Brain MRI Scan within the last 12 months prior to the study enrollment date?	○ No ○ Yes	
* If yes, date of latest MRI within the last 12 months prior to the study enrollment date		(UNK-UNK-UNK)

Results:

Number of Gadolinium-enhancing (Gd+) lesions identified on T1 weighted MRI of the brain

None	☐
Min_One	☐

Number of new or newly enlarged hyperintense lesions on T2-weighted MRI of the brain

Zero (0)	☐
One_Two (1-2)	☐
Three_Eight (3-8)	☐

Nine_Plus (9+)	☐

Prior MS Treatment

* Any prior MS treatment (other than Ocrelizumab) within 6 months prior to last menstrual period?	○ No ○ Yes

If yes, please complete the Prior MS Treatment form.

Prior MS Treatment

[Revision: Initial revision of study]

(Visit ID = 10 / Visit Display Name = Enrollment / Visit Abbrev = ENROLL / PageID = 90 (*) / Page Display Name = Prior MS Treatment / Description = Prior MS Treatment)

Sequence Number	
* Treatment Name	○ Glatiramer Acetate ○ Interferon 1A SC 22ug ○ Interferon 1A SC 44ug ○ Interferon 1A IM ○ Interferon 1B ○ Peginterferon Beta 1A ○ Dimethyl Fumarate ○ Fingolimod ○ Teriflunomide ○ Natalizumab ○ Alemtuzumab ○ Azathioprine ○ Cyclophosphamide ○ Mycophenolate Mofetil ○ Methotrexate ○ Mitoxantrone ○ Cyclosporine ○ Cladribine ○ Daclizumab ○ Other
* If Other, please specify	

* Start Date		(UNK-UNK-UNK)
* End Date		(UNK-UNK-UNK)
* Reason for stopping treatment	○ Pregnancy or Pregnancy planning ○ Lack of Efficacy ○ Tolerability ○ Adverse Event/Serious Adverse Event ○ Insurance ○ Medication error ○ Patient preference / patient decision ○ Progressive Multifocal Leucoencephalopathy (PML) risk ○ John Cunningham Virus (JCV) positive ○ Unknown reason ○ Malignancy ○ Other	
* If Other, please specify		

Pregnancy Info.

[Revision: Initial revision of study]

(Visit ID = 10 / Visit Display Name = Enrollment / Visit Abbrev = ENROLL / PageID = 100 / Page Display Name = Pregnancy Info. / Description = Pregnancy Info.)

Current Pregnancy		
* Date of Last Menstrual Period		(DD-MMM-YYYY)
* Has the patient received any vaccinations since the date of last menstrual period?	○ No ○ Yes	

If Yes:

Vaccination Name	Other, specify	Vaccination Date

○ Influenza (IIV, RIV, LAIV, IIV3)			(DD-MMM-YYYY)
○ Tetanus, diphtheria, pertussis (Tdap)			
○ Tetanus and diphtheria toxoids (Td)			
○ Diphtheria (d)			
○ Tetanus (TT)			
○ Pertussis (acp)			
○ Haemophilus influenzae type b (Hib)			
○ Hepatitis A (HepA)			
○ Hepatitis B (HepB)			
○ Human papillomavirus (HPV)			
○ Measles (MEAS)			
○ Measles, mumps, rubella (MMR)			
○ Meningococcal disease (MenACWY, MenB)			
○ Pneumococcal disease (PCV13, PPSV23)			
○ Poliomyelitis (IPV)			
○ Varicella (VAR)			
○ Other			

- Influenza (IIV, RIV, LAIV, IIV3)
- Tetanus, diphtheria, pertussis (Tdap)
- Tetanus and diphtheria toxoids (Td)
- Diphtheria (d)
- Tetanus (TT)
- Pertussis (acp)
- Haemophilus influenzae type b (Hib)
- Hepatitis A (HepA)
- Hepatitis B (HepB)
- Human papillomavirus (HPV)
- Measles (MEAS)
- Measles, mumps, rubella (MMR)
- Meningococcal disease (MenACWY, MenB)
- Pneumococcal disease (PCV13, PPSV23)
- Poliomyelitis (IPV)
- Varicella (VAR)
- Other

(DD-MMM-YYYY)

○ Influenza (IIV, RIV, LAIV, IIV3) ○ Tetanus, diphtheria, pertussis (Tdap) ○ Tetanus and diphtheria toxoids (Td) ○ Diphtheria (d) ○ Tetanus (TT) ○ Pertussis (acp) ○ Haemophilus influenzae type b (Hib) ○ Hepatitis A (HepA) ○ Hepatitis B (HepB) ○ Human papillomavirus (HPV) ○ Measles (MEAS) ○ Measles, mumps, rubella (MMR) ○ Meningococcal disease (MenACWY, MenB) ○ Pneumococcal disease (PCV13, PPSV23) ○ Poliomyelitis (IPV) ○ Varicella (VAR) ○ Other			(DD-MMM-YYYY)

* Expected Date of Delivery		(DD-MMM-YYYY)
* Has the patient received any prenatal testing for their current pregnancy, prior to enrollment that can provide knowledge of the pregnancy outcome?	○ No ○ Yes	

Test Name	Date of test		Result
Amniocentesis		(DD-MMM-YYYY)	
Genetic testing		(DD-MMM-YYYY)	
Nuchal translucency screen		(DD-MMM-YYYY)	
Chorionic villus sampling		(DD-MMM-YYYY)	
Late term ultrasound		(DD-MMM-YYYY)	

Pregnancy History

* Number of previous term live births (≥ 37 weeks gestation)		(format xx)
* Number of previous preterm live births (< 37 weeks gestation)		(format xx)
* Number of previous spontaneous abortions (< 20 weeks)		(format xx)
* Number of previous late fetal deaths/stillbirths (≥ 20 weeks gestation)		(format xx)
* Any previous elective or therapeutic terminations?	○ No ○ Yes	

If yes, please provide gestational age and reason for each termination.

Gestational age - weeks	Reason for termination	Reason for termination, Other, specify
(xx)	○ Prenatal testing finding ○ Maternal health ○ Psychosocial/non-medical reasons ○ Other	
(xx)	○ Prenatal testing finding ○ Maternal health ○ Psychosocial/non-medical reasons ○ Other	
(xx)	○ Prenatal testing finding ○ Maternal health ○ Psychosocial/non-medical reasons ○ Other	

* Does the patient have a history of any obstetrical complications during previous pregnancies?
○ No
○ Yes

If Yes, check all that apply:

- Gestational diabetes ☐
- Preeclampsia ☐
- Pregnancy-induced hypertension (PIH) ☐
- Toxoplasmosis ☐
- Oligohydramnios ☐
- Polyhydramnios ☐
- Cervical incompetence ☐
- Preterm labor ☐

Rh incompatibility	☐
Placenta previa	☐
Placenta abruption	☐
Antepartum haemorrhage	☐
Non-elective caesarean section	☐
Premature membrane rupture	☐
Chorioamnionitis	☐
Thromboembolism (deep vein thrombosis, pulmonary embolism)	☐
Eclampsia	☐
Viral infection (check all that apply):	☐
Specific infection unknown	☐
Cytomegalovirus	☐
Herpes	☐
Measles	☐
Parvovirus B19	☐
Rubella	☐
Other	☐
* Other, specify	
Bacterial infection (check all that apply):	☐
Specific infection unknown	☐
Chlamydia	☐
Group B strep	☐
Listeriosis	☐
Syphilis	☐
Other bacterial infection	☐
* Other, specify	
Other obstetrical complication	☐

* Other, specify	
Did any prior pregnancy have the following diagnosis:	
* Positional deformity	○ No ○ Yes
* Low birth weight	○ No ○ Yes
* Intrauterine growth restriction (IUGR) or small for gestational age	○ No ○ Yes
* Large for gestational age	○ No ○ Yes
* Other adverse fetal outcomes	○ No ○ Yes
* Specify details	
* Details unknown	○ No ○ Yes
* Congenital abnormalities	○ No ○ Yes
* Specify abnormalities	

Family History

[Revision: Initial revision of study]

(Visit ID = 10 / Visit Display Name = Enrollment / Visit Abbrev = ENROLL / PageID = 110 / Page Display Name = Family History / Description = Family History)

Family Reproductive History

	Multiple births	Congenital malformations	If Yes, specify	Spontaneous abortions	Premature births	Chromosomal anomalies	Developmental delays
Father	○ No ○ Yes	○ No ○ Yes		○ No ○ Yes	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes
Mother's Family	○ No ○ Yes	○ No ○ Yes		○ No ○ Yes	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes
Father's Family	○ No ○ Yes	○ No ○ Yes		○ No ○ Yes	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes

Family MS History

* Are there any family members with MS?
- ○ No
- ○ Yes

If Yes, please complete the Family MS History Details form.

Family MS History Details

[Revision: Initial revision of study]

(Visit ID = 10 / Visit Display Name = Enrollment / Visit Abbrev = ENROLL / PageID = 120 (*) / Page Display Name = Family MS History Details / Description = Family MS History Details)

Sequence number		
* Family member	○ Mother ○ Father ○ Other	
* Other, specify		
* MS Type	○ Relapsing Remitting MS (RRMS) ○ Secondary Progressive MS (SPMS) ○ Primary Progressive MS (PPMS) ○ Clinically Isolated Syndrome (CIS) ○ Radiologically Isolated Syndrome (RIS) ○ Unknown	
* Age at diagnosis		(format xx)

Risk Factors

[Revision: Initial revision of study]

(Visit ID = 10 / Visit Display Name = Enrollment / Visit Abbrev = ENROLL / PageID = 130 / Page Display Name = Risk Factors / Description = Risk Factors)

* Has there been a change in lifestyle risk factors since the last contact?	○ No ○ Yes
* Does the patient smoke cigarettes or use tobacco?	○ Never ○ Before pregnancy ○ During pregnancy ○ Patient declined to answer ○ Unknown
* Does the patient smoke cigarettes or use tobacco?	○ Never ○ During pregnancy ○ Patient declined to answer ○ Unknown
* Does the patient consume caffeine?	○ No ○ Yes ○ Unknown
* About how many caffeinated beverages per day (on average)?	○ Less than 3 ○ 3 or more
* Does the patient consume alcohol?	○ Never ○ Before pregnancy ○ During pregnancy ○ Patient declined to answer ○ Unknown

* Does the patient consume alcohol?	○ Never ○ During pregnancy ○ Patient declined to answer ○ Unknown	
* Number of alcoholic drinks per week		(format xx)
Unknown	☐	
* Does the patient use illicit drugs?	○ No ○ Yes ○ Unknow	