Fig. S1 Physician Treatment Selection Assessment Survey
(a)

PHYSICIAN TREATMENT SELECTION ASSESSMENT SURVEY
NEW SYSTEMIC THERAPY

Site Number: _____ Provider Name: _____ Date of Visit: --/--/---- (DD MM YYYY)
8-digit Subject ID: _____ Subject Name: _____
Prescribed Therapy: _____

SECTION A: NO SYSTEMIC THERAPY SELECTED FOR THE PATIENT
Please select the primary reason and up to two (2) secondary reasons for NOT initiating therapy.

Primary Reason *(SELECT ONE)*	Secondary Reason *(OPTIONAL)*	Secondary Reason *(OPTIONAL)*
□ Active surveillance, no evidence of disease following procedure	□ Active surveillance, no evidence of disease following procedure	□ Active surveillance, no evidence of disease following procedure
□ Active surveillance, disease present	□ Active surveillance, disease present	□ Active surveillance, disease present
□ Poor prognosis – supportive care, without Hospice	□ Poor prognosis – supportive care, without Hospice	□ Poor prognosis – supportive care, without Hospice
□ Poor prognosis – Hospice enrollment	□ Poor prognosis – Hospice enrollment	□ Poor prognosis – Hospice enrollment
□ Unable to afford treatment	□ Unable to afford treatment	□ Unable to afford treatment
□ Patient declined treatment	□ Patient declined treatment	□ Patient declined treatment
□ Local therapy (metastasectomy, etc)	□ Local therapy (metastasectomy, etc)	□ Local therapy (metastasectomy, etc)
□ Other *(SPECIFY)*: _____	□ Other *(SPECIFY)*: _____	□ Other *(SPECIFY)*: _____

SECTION B: NEW SYSTEMIC THERAPY SELECTED FOR THE PATIENT
Please select the primary reason and up to two (2) secondary reasons why you chose the mRCC agent for the patient. For combination therapies, please indicate reasons in relation to the combination as a whole.

Primary Reason *(SELECT ONE)*	Secondary Reason *(OPTIONAL)*	Secondary Reason *(OPTIONAL)*
Patient Characteristics	**Patient Characteristics**	**Patient Characteristics**
□ Age	□ Age	□ Age
□ Performance status/frailty	□ Performance status/frailty	□ Performance status/frailty
□ Prognostic factors (MSKCC, Heng risk)	□ Prognostic factors (MSKCC, Heng risk)	□ Prognostic factors (MSKCC, Heng risk)
□ Comorbidities *(SPECIFY)*: _____	□ Comorbidities *(SPECIFY)*: _____	□ Comorbidities *(SPECIFY)*: _____
Likelihood of Clinical Benefit	**Likelihood of Clinical Benefit**	**Likelihood of Clinical Benefit**
□ Potential for Tumor regression	□ Potential for Tumor regression	□ Potential for Tumor regression
□ Overall survival/progression-free survival	□ Overall survival/progression-free survival	□ Overall survival/progression-free survival
□ Patient quality of life	□ Patient quality of life	□ Patient quality of life
□ Other *(SPECIFY)*: _____	□ Other *(SPECIFY)*: _____	□ Other *(SPECIFY)*: _____
Side Effect Profile	**Side Effect Profile**	**Side Effect Profile**
□ Less Cardiac toxicities	□ Less Cardiac toxicities	□ Less Cardiac toxicities
□ Less GI toxicities	□ Less GI toxicities	□ Less GI toxicities
□ Less Fatigue	□ Less Fatigue	□ Less Fatigue
□ Less Metabolic toxicities	□ Less Metabolic toxicities	□ Less Metabolic toxicities
□ Other *(SPECIFY)*: _____	□ Other *(SPECIFY)*: _____	□ Other *(SPECIFY)*: _____
Other	**Other**	**Other**
□ Patient preference	□ Patient preference	□ Patient preference
□ Cost	□ Cost	□ Cost
□ Other *(SPECIFY)*: _____	□ Other *(SPECIFY)*: _____	□ Other *(SPECIFY)*: _____

Prescribing Physician Signature: _____ **Date:** _____

Physician Treatment Selection Assessment Survey *Pfizer MaRCC Registry, version 2.0 created 10/20/2014*

(b)

PHYSICIAN TREATMENT SELECTION ASSESSMENT SURVEY
DISCONTINUING SYSTEMIC THERAPY

Site Number: _____ Provider Name: _____ Date of Visit: __/__/____ DD MM YYYY

8-digit Subject ID: _____ Subject Name: _____

Prescribed Therapy: _____

Please select the **PRIMARY REASON** for discontinuing the most immediate prior systemic therapy with the patient.

☐ **Toxicity (GO TO C1)** ☐ **Disease Progression (GO TO C2)** ☐ **Other (GO TO C3)**

C1. Please indicate the **PRIMARY** and **SECONDARY** toxicities and **1 ADDITIONAL (optional)** toxicity the patient experienced that led to your decision to remove the patient from systematic therapy.

Primary Toxicity *(SELECT ONE)*	**Secondary Toxicity *(SELECT ONE)***	**Secondary Toxicity *(OPTIONAL)***
Constitutional	**Constitutional**	**Constitutional**
☐ Fatigue/ Asthenia	☐ Fatigue/ Asthenia	☐ Fatigue/ Asthenia
☐ Arthralgia	☐ Arthralgia	☐ Arthralgia
Gastrointestinal	**Gastrointestinal**	**Gastrointestinal**
☐ Soreness in mouth/throat	☐ Soreness in mouth/throat	☐ Soreness in mouth/throat
☐ Diarrhea	☐ Diarrhea	☐ Diarrhea
☐ Nausea/vomiting	☐ Nausea/vomiting	☐ Nausea/vomiting
☐ Abdominal pain	☐ Abdominal pain	☐ Abdominal pain
☐ Loss of appetite	☐ Loss of appetite	☐ Loss of appetite
Cardiovascular and Pulmonary	**Cardiovascular and Pulmonary**	**Cardiovascular and Pulmonary**
☐ Hypertension	☐ Hypertension	☐ Hypertension
☐ Cardiac dysfunction	☐ Cardiac dysfunction	☐ Cardiac dysfunction
☐ Pneumonitis	☐ Pneumonitis	☐ Pneumonitis
Dermatologic/Skin	**Dermatologic/Skin**	**Dermatologic/Skin**
☐ Soreness in hands/feet	☐ Soreness in hands/feet	☐ Soreness in hands/feet
☐ Rash	☐ Rash	☐ Rash
Hematologic and Laboratory	**Hematologic and Laboratory**	**Hematologic and Laboratory**
☐ Hemorrhage	☐ Hemorrhage	☐ Hemorrhage
☐ Anemia	☐ Anemia	☐ Anemia
☐ Neutropenia	☐ Neutropenia	☐ Neutropenia
☐ Thrombocytopenia	☐ Thrombocytopenia	☐ Thrombocytopenia
☐ Increased AST, ALT or Bilirubin	☐	☐ Increased AST, ALT or Bilirubin
☐ Increased Creatinine	☐ Increased Creatinine	☐ Increased Creatinine
Other *(SPECIFY)*:	☐ None	**Other *(SPECIFY)*:**
_____	☐ **Other *(SPECIFY)*:** _____	☐ _____

C2. Please select the **PRIMARY** indicator(s) of **DISEASE PROGRESSION** that led to discontinuation of systemic treatment for the patient.

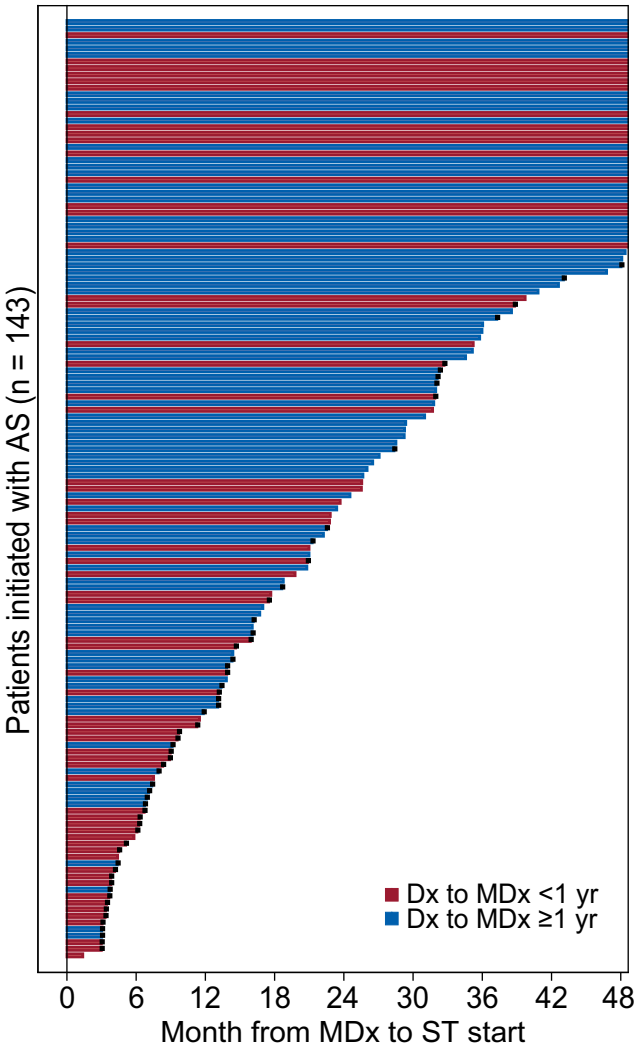
- □ New lesion(s) within already involved body organ (radiographic)
- □ New lesion(s) in entirely new body organ (radiographic)
- □ Growth of existing lesion(s) (radiographic)
- □ Symptomatic, disease related (not treatment related toxicity)
- □ Other *(SPECIFY)*: _____

C3. Please select the other reason that led to discontinuation of systemic treatment for the patient.

- □ Patient declined ongoing treatment
- □ Cost/ Unable to afford treatment
- □ Other *(SPECIFY)*: _____

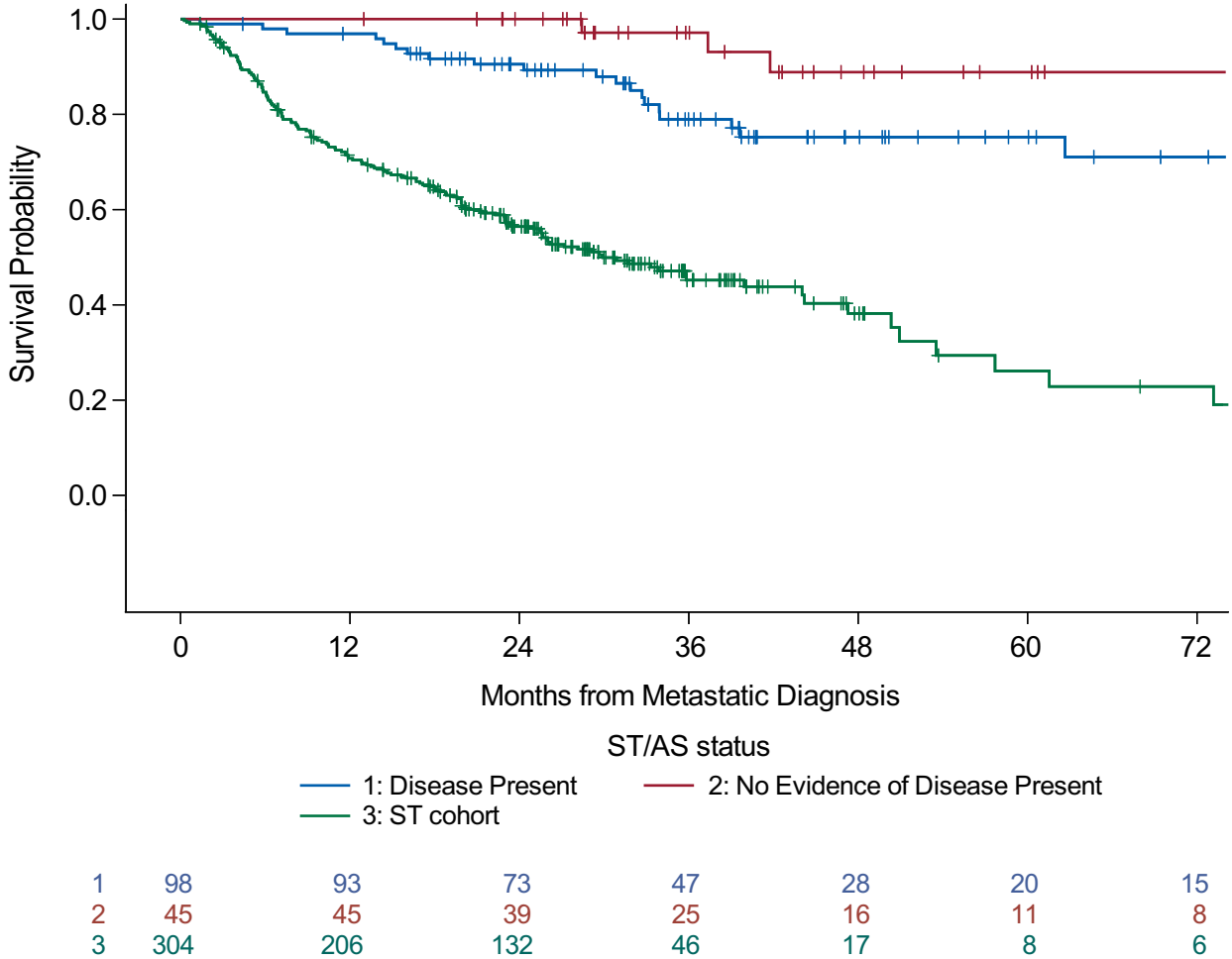
Prescribing Physician Signature: _____ **Date:** _____

Fig. S2 The duration of time on AS



Footnote: AS, active sureillance; Dx, diagnosis; MDx, metastatic diagnosis; ST, systemic therapy. Each bar represents 1 patient. A square at the end of the bar indicates the patient initiated ST.

Fig. S3 Kaplan-Meier curves for OS in disease present, no evidence of disease present, and ST cohorts



Footnote: AS, active surveillance; OS, overall survival; ST, systemic therapy.