## CADTH REIMBURSEMENT REVIEW

# Patient and Clinician Group Input

**pembrolizumab (Keytruda)**

(Merck Canada)

**Indication:** Keytruda, in combination with fluoropyrimidine- and platinum-containing chemotherapy, is indicated for the first-line treatment of adult patients with locally advanced unresectable or metastatic HER2-negative gastric or gastroesophageal junction (GEJ) adenocarcinoma.

**April 2, 2024**

# Patient Input

## 1 Patient Input for CADTH CDR and pCODR Programs

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|---|---|
| **Name of the Drug and Indication** | Keytruda, in combination with fluoropyrimidine- and platinum-containing chemotherapy, is indicated for the first-line treatment of adult patients with locally advanced unresectable or metastatic HER2-negative gastric or gastroesophageal junction (GEJ) adenocarcinoma. |
| **Name of the Patient Group** | My Gut Feeling - Stomach Cancer Foundation of Canada |
| **Author of the Submission** | Ekaterina Kosyachkova and Teresa Tiano |
| **Name of the Primary Contact for This Submission** | Ekaterina Kosyachkova |
| **Email** | [redacted] |
| **Telephone Number** | [redacted] |

### 1. About Your Patient Group

My Gut Feeling – Stomach Cancer Foundation of Canada is the first non-profit organization in Canada, dedicated to providing support, awareness, education, information and advocacy to stomach cancer patients, survivors and caregivers. My Gut Feeling was founded by two stomach cancer survivors; although the organization was initially developed to help people affected by stomach cancer, people with gastroesophageal (GEJ) and esophageal cancer are included in our service programs and receive ongoing support. Our mission is to improve the quality of life for people affected by GEJ cancers and to make systemic changes to reduce incidence and mortality of GEJ cancers. We strive to give a voice to patients and caregivers, and provide peer mentorship based on lived experience with cancer.

Website: https://mygutfeeling.ca

## 2. Information Gathering

In order to represent the patient and caregiver voice, My Gut Feeling - Stomach Cancer Foundation of Canada conducted an international online survey to understand the perspective of patients and caregivers affected by gastric, esophageal and/or gastroesophageal (GEJ) cancer including experiences with current treatment and the novel immunotherapy under review. My Gut Feeling launched this survey between March 12 to March 25, 2024. The survey link was posted on My Gut Feelings's social media platforms (including Facebook, Instagram and Twitter) as well as the email distribution list for all members. The survey was also shared with patients through additional organizations including: Gastrointestinal Society, Colorectal Cancer Resource & Action Network (CCRAN) and the Canadian Cancer Society. through email and their social media channels.

In total, forty-nine people completed the survey, of those, 79.6% identified as a patient and 20.4% identified as a caregiver. Specifically, 46.9% identified as a patient who completed treatment and 32.7% as a patient in current treatment. The majority, 79.6% of respondents identified as female and 20.4% identified as male. Respondents were diagnosed across all ages ranging from 20 to 80 years old: 20-30 years (2%), 31-40 years (26.5%), 41-50 years (18.4%),

51 to 70 years (14.3%), 61 to 70 years (30.6%), and 71-80 years (8.2%). Data was gathered internationally with 69.4% of respondents residing in Canada, 29.6% in the United States and 1% residing outside of North America. To ensure unbiased data collection, respondents were asked to refrain from using personal identifiers to preserve anonymity.

Respondents included in this survey had a diagnosis of gastric, esophageal and/or gastroesophageal (GEJ) cancer. The majority of respondents (86.7%) had gastric cancer and the remainder had either esophageal and/or GEJ cancer. Of the respondents, 18.4% were diagnosed with stage one, 18.4% with stage two, 26.5% with stage three, 36.7% with stage four. When the cancer metastasized, in 22.5% it had spread to lymph nodes, 18.5% to peritoneum, 12.6% to liver and the remainder to other locations including the lungs, brain, bowel and pelvic structures. Most patients (85.7%) had adenocarcinoma; most patients were HER-2 negative with only 12.0% of respondents having HER-2 positive disease.

## 3. Disease Experience

Most respondents (95%), felt that the cancer diagnosis had a *significant* impact on their quality of life, whereas (5%) felt it had a *minimal* impact and no patients (0%) felt it had *no* impact on their quality of life. Areas affected were physical health, mental health, ability to eat, work, finances, social life, identity, and personal image. We received an overwhelming number of direct quotes from patients and caregivers describing their disease experience; we attempted to select direct quotes that best exemplified these challenges. Respondents commented on the physical implications of cancer and its

treatment. Symptoms of weight loss, nausea, pain and fatigue were mentioned most by respondents. For example, one patient describes their experience: “after only 4 rounds of chemo and gastrectomy, I was bedridden for weeks and had a very difficult time eating. My weight plummeted to 85 lbs. I was very unsteady on my feet and couldn’t lift up my legs to get up any steps. I had to be helped into bed. I bruise easily and my finger and toenails all turned black. Acid/bile reflux was a real problem and still causes pain in my chest”... “My cancer came back after surgery. I feel awful every single minute of the day, I am constantly throwing up and having diarrhea and I have no more energy to fight”.

Both patient and caregiver respondents and especially those with metastatic disease, reported a significant decline in their mental health due to the cancer diagnosis and its treatment. For example, one patient described feeling hopeless due to being diagnosed with metastatic disease. “Given a stage 4 diagnosis [the patient was] given a 6-12 month survival rate even with treatment. [They were] told the cancer was inoperable and terminal and that chemo and immunotherapy would only continue until [their] body couldn’t handle the side effects…Despite being young, [the patient] was told that there were a handful of treatments available and they would eventually run out of options''. Caregiver respondents echoed feelings of helplessness. For example, one caregiver described “watching [their] husband become a bag of bones and husband suffer through chemo”..this made the caregiver “fall into depression”. In addition to mental health implications, a cancer diagnosis can lead to changes in identity impacting the patients' ability to maintain relationships. One patient responded that cancer “had a significant impact on [their] life, changing how [they] interacted with almost everyone in [their] orbit. Intimacy became nearly nonexistent as chemo treatments crushed [their] libido”. Another patient described her journey as a mother with 2 young teenagers. This patient felt like “[they were] a burden on [their] family…As a result of the diagnosis and limited treatment options, [the patient] struggled with [their] duties as a mother…[The patient] felt like [she] was missing out on [her] children’s lives by being hit with depression and anxiety, simultaneously not wanting to leave the house or be away from [her] kids and wanting to be alone''. Changes in identity and family dynamics further impacted psychosocial well-being and exacerbated any pre-existing mental health conditions such as depression and anxiety in both patients and caregivers.

Cancer and its treatments had financial implications on the patient and caregiver. Many respondents had concerns over finances due to inability to work due to the diagnosis and/or treatment for cancer. Many patients took sick leave or stopped working due to the physical and mental health side-effects of chemotherapy and/or surgery. Patients and caregivers commented on the time and money lost to attending cancer treatment appointments citing parking, gas, food in hospital, prescription medications and private pay immunotherapy as a financial strain for patients and caregivers. For example, one patient wrote that “since [they] could not drive or take public transit, they relied on taxis…With many prescriptions not being covered by the province [the patient] had to use previous years of income…after two years [the patient] had to file for bankruptcy”. While some patients did return to work, many respondents commented on being on permanent disability during and after treatment, for example, one patient reported being

" unable to have a regular job because of [their] need to eat often, digestive pain, weakness and fatigue [making] it hard to have a regular life and job".

Objectively when asked to rank symptom burden, respondents commented that both the cancer itself and the treatments to control the cancer played a major impact on their daily living.

Patients and caregivers were asked if any cancer symptoms were experienced *prior* to diagnosis. All (100%) of respondents had experienced at least one symptom *prior* to being diagnosed.

Weight loss (61.2%), changes in appetite (59.2%), pain (46.9%), reflux (42.9%), nausea/vomiting (36.7%) and difficulty swallowing (34.7%) were the most reported symptoms. Other symptoms including bleeding, feeling a mass, changes in lab work, bowel obstruction, ascites and jaundice were also reported by respondents (figure

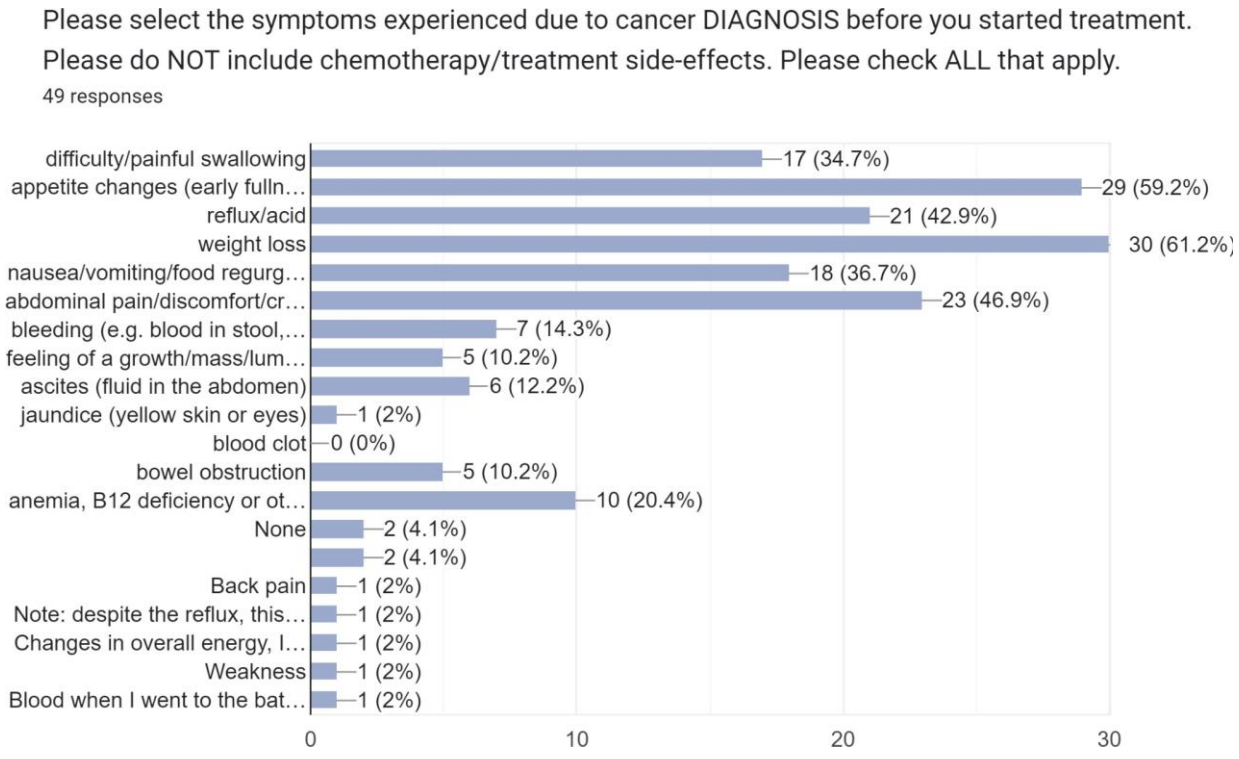


Figure 1. Patient and caregiver reported symptoms prior to diagnosis with gastric, esophageal or gastroesophageal cancer.

## 4. Experiences With Currently Available Treatments

Respondents reported that they had experience with a variety of treatment modalities. Of those that pursued treatment: 79.6% had chemotherapy alone or in combination with immunotherapy, 18.4% received surgery and 2% received other treatments (including radiation). Only 22.4% of patients were offered a clinical trial and 77.6% received standard of care treatments.

Participants were asked to evaluate the effectiveness of their treatment on a scale of 1 to 10 (1 = “not effective”, 10 = “very effective”). Figure 2 demonstrates that responses were split.

Respondents were able to comment on why they gave the specific ranking. Those that ranked their care as five and below cited recurrence, tumor progression, side effects and lack of alternatives as the reason for finding the treatment less effective. For example one patient stated “the chemo worked at first, but then stopped working after 5 months, and then there were no options. Not sure if all the suffering during chemo outweighed the benefits”. Some respondents felt that despite disease stability, the quality of life implications lead to dissatisfaction with current therapies. Many respondents were not able to distinguish whether their symptoms came from the chemotherapy or the immunotherapy. One patient made an interesting distinction stating “[they] rated the use of Folfox [which they rated as a 5] to represent the fact that it did work for 1 year. If [they] were to rate Keytruda [they] would give it a ten because the

side-effects were mild in comparison and it worked for a long time”. The respondents that replied with a rating of greater than 5 cited that they were satisfied with their treatment because it caused the cancer to shrink, caused a reduction of symptom burden or resulted in remission.

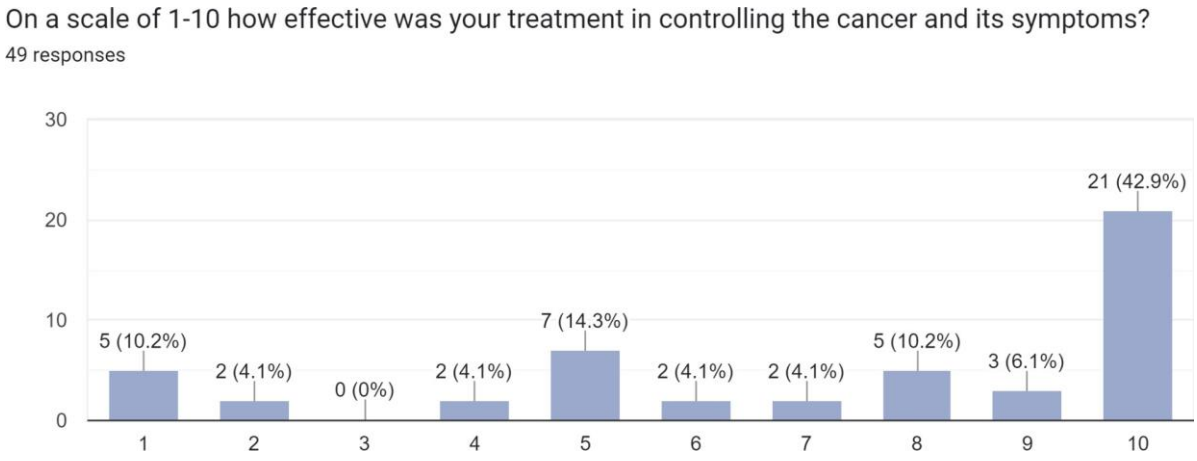


Figure 2. Respondents were given an opportunity to evaluate the efficacy of their cancer treatment

While current therapies lead to mixed satisfaction from respondents in terms of perceived efficacy and cancer control, current treatments have a variety of side effects impacting quality of life. All respondents identified at least one treatment related side effect with 89.8% reporting fatigue. Other common symptoms included weight loss

(83.7%), appetite changes (79.6%), nausea/vomiting (75.5%), chemo brain (73.5%), taste changes (69.4%), neuropathy (67.3%),

hair loss (65.3%), diarrhea (61.2%), abdominal pain (51%) and insomnia (46.9%). Less commonly reported symptoms included reflux, constipation, anemia, blood clots, infection, body aches, skin rash, hand-foot syndrome, mucositis, dumping syndrome and blood-work abnormalities (figure 3). Respondents were able to leave additional comments regarding their treatment experiences. We asked respondents to identify the top 3 "worst" symptoms from treatment. While fatigue and appetite changes leading to weight loss were reported as some of the worst side effects of treatment, there was no overall consensus regarding the functionally impairing side-effects of treatment.While most were able to tolerate treatment as prescribed (42.9%), 8.2% respondents had to stop treatment because of being hospitalized for an adverse event, 16.4% received a dose reduction in treatment and 16.4% had to delay or skip a treatment cycle of systemic therapy. The analysis from this short survey demonstrates that current systemic therapy to treat gastro-esophageal cancers has a significant impact on patient morbidity and quality of life.

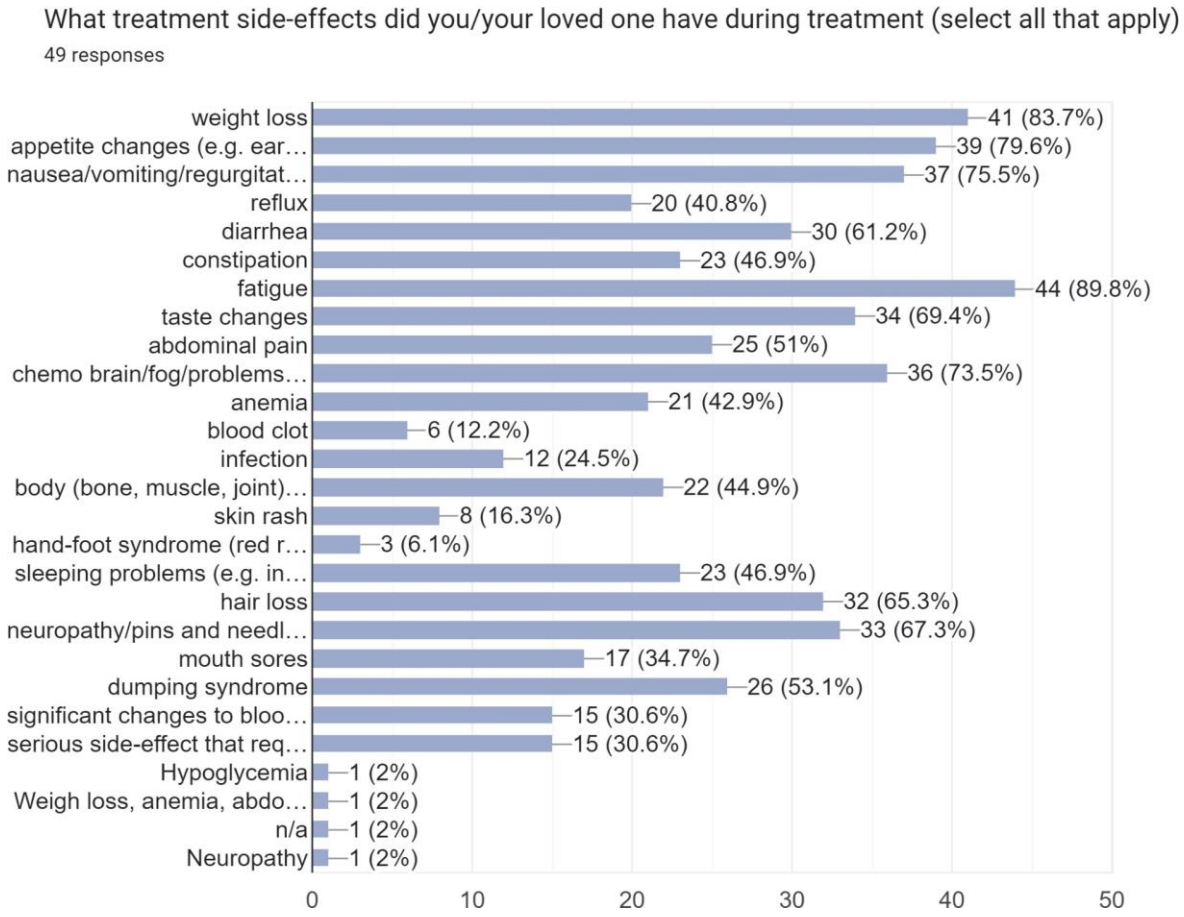


Figure 3. Patient and caregiver reported side effects while on treatment for gastric, esophageal or gastroesophageal cancer.

## 5. Improved Outcomes

When evaluating their treatment options, patients and caregivers considered multiple factors such as quality of life, treatment side effects, cost of treatment, convenience of treatment, duration of treatment and the survival benefits. Respondents recognized that treatments had trade-offs and each respondent placed a different value on these considerations based on their preferences. For example, when asked *"how important is it for you that new therapies bring about improvement in quality of life"*. Almost all respondents (85.7%) replied with a 10 or "extremely important". When asked "how important is it to advocate for NEW treatment options for gastric, esophageal and gastroesophageal cancer", 93.9% of respondents replied with a 10 or "extremely important". While cancer control was an important consideration, treatment came at a cost to quality of life which may not be tolerable to all patients. For example, one patient wrote

"[they] had a small recurrence of their cancer after surgery. Small enough that [they] had no symptoms and it was only found on CT…re-starting chemo was terrible, [they] went from feeling good, to experiencing all the chemo symptoms before fully recovering from surgery…Ultimately [they] stopped chemo so I could spend more time with family instead of feeling sick from chemo". Convenience of treatment was another consideration for patients and caregivers. For example patients preferred oral chemotherapy taken at home to an IV chemotherapy administered in a hospital setting, favouring less frequent visits to the hospital and shorter time in the chemo chair. Patient's also reported that when they felt well on chemo, they wanted to have less frequent visits with the oncology team, for example one patient wrote that "when the cancer was stable on chemo-immunotherapy, [they] appreciated only having to see the oncologist once per month; those oncologist appointments would sometimes take an entire day, no matter what time the appointment was and when [they] were feeling well, there was little to discuss with the team". Convenience and the focus on quality of life in the palliative setting can be just as important as longevity when considering treatment options.

We asked respondents if they would pay out of pocket for additional therapies. The majority of respondents were interested in discussing treatment options even if they were not covered by their current healthcare plan or universal healthcare. Most, 79.6% of respondents replied that they would "maybe" pay for these treatments if the treatment improved survival (18.5%), maybe

- depending on cost (24.5%) and maybe - depending on impact on quality of life (36.7%). This once again demonstrates that while survival is important, respondents place different values on quality versus quantity of life. While our survey found that most people (87.8%) did not have to pay directly out of pocket for specific treatments, the remainder of respondents (12.2%) paid for either some targeted therapy or adjunct medications either through private pay or insurance. One patient disclosed that it cost "over $15,000 per

month to get immunotherapy at a private clinic before OHIP accepted immunotherapy as the new standard with chemo". Another patient estimated that they spent over $7,000 on adjunct medications such as anti-emetics, iron infusions, blood thinner, etc. With the onset of biomarker testing in gastro-esophageal cancers, the universal healthcare system and private insurance lags behind, leaving Canadians with the bill for targeted therapies and adjective medications.

Our survey findings also showed that treatment access varied by geographic location. Clinical trials and novel therapies were more readily available in larger cancer centres that tend to be in Metropolitan areas. Respondents identified that access to first line therapies was "*extremely important"* to them. A patient wrote that "[they] wished they knew all their options at the start since every treatment was a lifeline…Understanding [their] cancer biomarkers and seeking trials was a top priority to get as much time as possible". Barriers to access identified included institutional and health care system barriers, limited availability of treatment and how quickly treatment could be accessed. Respondents had many great suggestions in terms of how to better access treatment. For example, one patient wrote that they wished to have "a list of all the trials available in Canada to discuss with my doctor right from the start". Another patient recommended that "healthcare professionals [should be] better trained and informed on a patient's cancer biology, and make sure they pass along that info to patients and caregivers since it makes a huge difference in better care options. Patients and caregivers should have more potential options, not less. [patients] shouldn't have to depend on social media to find groups like My Gut Feeling for information on treatment and there HAS to be better coverage by OHIP and the government to help patients on their cancer journey. NO ONE should have to go into debt to save their lives"! While current treatments options may improve patient survival, there are clear limitations in available treatment options, access to new therapies and patient centred discussion regarding options. Patients and caregivers want more options from which to choose so that they can make informed decisions based on their values and preferences.

## 6. Experience With Drug Under Review

Based on our survey, nine respondents had experience with Pembrolizumab (Keytruda), the drug under review. Three respondents received Pembrolizumab as part of a clinical trial, four respondents received the drug through compassionate access through the pharmaceutical company and two received the drug as part of private-pay. At the time of the survey, 75% were actively on this drug and had been on it for at least one month; the remainder discontinued the drug after disease progression. Participants commented that they were satisfied with this drug primarily because it had fewer side-effects and was more convenient than their standard of care treatment such as chemotherapy alone. Fatigue continued to be the most reported symptom (66.7%), however overall the side effect profile appeared to be much less relative to standard of care treatment. When asked to rate the statement *"compared to other previous treatments Pembrolizumab*

*(Keytruda) was easier to tolerate overall"* (1= "strongly disagree", 10= "strongly agree"), 100% of respondents ranked it a five or above with 66.7% rating the question as a 10. When asked to rate the statement *"Pembrolizumab (Keytruda) has improved my quality of life"* on a 1 to 10 scale (1= "strongly disagree", 10 = "strongly agree"), 80% selected five or greater. Respondents who were satisfied with the drug mentioned disease control, for example one patient stated "It seems to have reversed tumors in [their] lungs, adrenal glands, and lymph nodes and has stopped any additional spread in [their] vertebrae and ribs". Other patients were satisfied because of the minimal side effect profile, for example "compared to chemo, Pembro was a breeze! It stopped working eventually, but the 5 months it gave [them] was worth the cost because the only side-effect [they] had was fatigue which was not close to as bad as with chemo". While we do recognize that our survey only had nine respondents on Pembrolizumab, these anecdotes do demonstrate the need for patients and caregivers to have options and information on novel therapies that could improve the length and/or quality of life**.**

## 7. Companion Diagnostic Test

We did not ask questions related to companion diagnostic testing.

## 8. Anything Else?

Being diagnosed with any cancer is challenging. Gastric, esophageal and gastroesophageal cancers are rare in Canada with few treatment options. Biomarker testing is becoming routine in Canada. Novel biomarker targets are being tested rapidly in this cancer site. Personalized medicine based on biomarkers is on the rise. Drug combinations that attack multiple targets should be studied and the combinations that improve overall survival (OS) and progression free survival (PFS) should be rapidly expedited by CADTH as potential therapeutic options to fill the urgent and unmet need for gastro-esophageal cancers. For those patients and caregivers impacted by this diagnosis, having options brings about a sense of control and hope at a time when cancer strips the patient and family of their identity. This survey administered by My Gut Feeling shows that there is an unmet patient and caregiver need to receive equitable access to therapies that may prolong life, improve symptoms, reduce risk of recurrence and improve treatment tolerability. My Gut Feeling strongly supports the use of Keytruda, in combination with fluoropyrimidine- and platinum-containing chemotherapy, is indicated for the first-line treatment of adult patients with locally advanced unresectable or metastatic HER2-negative gastric or gastroesophageal junction (GEJ) adenocarcinoma.

From our survey results we drew the following conclusions:

1) Patients need to be informed about their biomarkers and eligible treatment

options without barriers before starting first line therapy. Treatment options should include information about standard of care options, clinical trials and self-pay options for novel therapies

2) Biomarker testing should be accessible to all Canadians at the onset of their disease

3) New targeted drug combinations improve both survival and quality of life. Patients and caregivers should have a choice in treatment options based on their own personal values and preferences. Treatment options should be available barrier free for all Canadians, covered under the universal healthcare system to benefit the subset of cancer patients that would benefit from this therapy.

**Appendix: Patient Group Conflict of Interest Declaration**

**To maintain the objectivity and credibility of the CADTH CDR and pCODR programs, all participants in the drug review processes must disclose any real, potential, or perceived conflicts of interest. This Patient Group Conflict of Interest Declaration is required for participation. Declarations made do not negate or preclude the use of the patient group input. CADTH may contact your group with further questions, as needed.**

**1. Did you receive help from outside your patient group to complete this submission? If yes, please detail the help and who provided it.**

No, My Gut Feeling independently completed this submission

**2. Did you receive help from outside your patient group to collect or analyze data used in this submission? If yes, please detail the help and who provided it.**

No, My Gut Feeling independently collected and analyzed data used for this submission

**3. List any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the drug under review.**

| Company | Check Appropriate Dollar Range |
|---|---|

| | $0 to 5,000 | $5,001 to 10,000 | $10,001 to 50,000 | In Excess of $50,000 |
|---|---|---|---|---|
| **Eli Lilly Canada Inc.** | X | | | |
| **Taiho Pharma Canada Inc.** | X | | | |
| **Bristol Myers Squibb** | | | X | |
| **Jazz Pharmaceuticals** | | | X | |

| | | | | |
|---|---|---|---|---|
| **Astra Zeneca** | | | | X |
| **Astellas** | | | X | |
| **Merk** | | | X | |
| **Daiichi Sankyo** | | | X | |

**I hereby certify that I have the authority to disclose all relevant information with respect to any matter involving this patient group with a company, organization, or entity that may place this patient group in a real, potential, or perceived conflict of interest situation.**

Name: Ekaterina Kosyachkova Position: Vice-Chair and Co-Founder

Patient Group: My Gut Feeling - Stomach Cancer Foundation of Canada Date: April 1, 2024

# Clinician Group Input

CADTH Project Number: PC0356-000

Generic Drug Name (Brand Name): pembrolizumab (Keytruda)

Indication: In combination with fluoropyrimidine- and platinum-containing chemotherapy, is indicated for the first-line treatment of adult patients with locally advanced unresectable or metastatic gastric or gastroesophageal junction (GEJ) adenocarcinoma.

Name of Clinician Group: Ontario Health (Cancer Care Ontario) Gastrointestinal Drug Advisory Committee

Author of Submission: Dr. Erin Kennedy

## 1. About Your Clinician Group

OH-CCO's Drug Advisory Committees provide timely evidence-based clinical and health system guidance on drug-related issues in support of CCO's mandate, including the Provincial Drug Reimbursement Programs (PDRP) and the Systemic Treatment Program.

## 2. Information Gathering

Information was gathered by email.

## 3. Current Treatments and Treatment Goals

The KN859 population includes patients with advanced, Her2-negative gastric cancer. In Canada, we currently offer these patients chemotherapy (usually FOLFOX, XELOX can be used as well) plus nivolumab. This study provides an alternative to this SOC combination.

Goals of treatment in the palliative setting include improvement of quality of life and overall survival.

## 4. Treatment Gaps (unmet needs)

### 4.1. Considering the treatment goals in Section 3, please describe goals (needs) that are not being met by currently available treatments.

This combination (chemotherapy + pembrolizumab) provides an alternative to the standard chemotherapy/Nivolumab. The two regimens have not been compared head to head, but seemed to perform similarly against chemotherapy alone in their respective trials.

Nivolumab and Pembrolizumab have similar side effect profiles, so it's unlikely that there are many patients that don't tolerate chemo/nivolumab who would then tolerate chemo/pembrolizumab.

## 5. Place in Therapy

### 5.1. How would the drug under review fit into the current treatment paradigm?

The addition of pembrolizumab would give clinicians an alternative option to nivolumab, which is currently approved.

### 5.2. Which patients would be best suited for treatment with the drug under review? Which patients would be least suitable for treatment with the drug under review?

Patients with HER2 negative advanced gastric cancer.

The approvals for both nivolumab and pembrolizumab (FDA) don't specify a PD-L1 CPS cutoff, although both studies (CM649 and KN859) suggest that those patients with PD-L1 CPS > 5% or 10% derive most benefit. The patients with PD-L1 CPS < 1% derive little benefit (although this is subgroup analysis).

### 5.3 What outcomes are used to determine whether a patient is responding to treatment in clinical practice? How often should treatment response be assessed?

- Clinical Response/Symptoms
- CT scans should be done regularly as per clinician discretion.

### 5.4 What factors should be considered when deciding to discontinue treatment with the drug under review?

- Disease Response and immune-related toxicities
- Functional Status

### 5.5 What settings are appropriate for treatment with [drug under review]? Is a specialist required to diagnose, treat, and monitor patients who might receive [drug under review]?

Patients should be under the care of a medical oncologist.

## 6. Additional Information

N/A

## 7. Conflict of Interest Declarations

To maintain the objectivity and credibility of the CADTH drug review programs, all participants in the drug review processes must disclose any real, potential, or perceived conflicts of interest. This conflict of interest declaration is required for participation. Declarations made do not negate or preclude the use of the clinician group input. CADTH may contact your group with further questions, as needed. Please see the *Procedures for CADTH Drug Reimbursement Reviews* (section 6.3) for further details.

1. Did you receive help from outside your clinician group to complete this submission? If yes, please detail the help and who provided it.

   OH (CCO) provided a secretariat function to the group.

2. Did you receive help from outside your clinician group to collect or analyze any information used in this submission? If yes, please detail the help and who provided it.

   No.

3. List any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the drug under review. **Please note that this is required for each clinician who contributed to the input — please add more tables as needed (copy and paste). It is preferred for all declarations to be included in a single document.**

Declaration for Clinician 1

**Name:** Dr. Erin Kennedy

**Position:** Lead, OH (CCO) Gastrointestinal Cancer Drug Advisory Committee

**Date:** 24-03-2024

☒ **I hereby certify** that I have the authority to disclose all relevant information with respect to any matter involving this clinician or clinician group with a company, organization, or entity that may place this clinician or clinician group in a real, potential, or perceived conflict of interest situation.

**Table 1: Conflict of Interest Declaration for Clinician 1**

| | **Check appropriate dollar range*** | | | |
|---|---|---|---|---|
| **Company** | **$0 to $5,000** | **$5,001 to $10,000** | **$10,001 to $50,000** | **In excess of $50,000** |
| Add company name | | | | |
| Add company name | | | | |
| Add or remove rows as required | | | | |

* Place an X in the appropriate dollar range cells for each company.

Declaration for Clinician 2

Name: Dr. Suneil Khanna

Position: Member, OH (CCO) Gastrointestinal Cancer Drug Advisory Committee

**Date:** 14-02-2024

☒ I hereby certify that I have the authority to disclose all relevant information with respect to any matter involving this clinician or clinician group with a company, organization, or entity that may place this clinician or clinician group in a real, potential, or perceived conflict of interest situation.

**Table 2: Conflict of Interest Declaration for Clinician 2**

| Company | Check appropriate dollar range* | | | |
|---|---|---|---|---|
| | **$0 to $5,000** | **$5,001 to $10,000** | **$10,001 to $50,000** | **In excess of $50,000** |
| Add company name | | | | |
| Add company name | | | | |
| Add or remove rows as required | | | | |

* Place an X in the appropriate dollar range cells for each company.

Declaration for Clinician 3

Name: Dr. Michael Raphael

Position: Member, OH (CCO) Gastrointestinal Cancer Drug Advisory Committee

Date: 22-03-2024

☒ I hereby certify that I have the authority to disclose all relevant information with respect to any matter involving this clinician or clinician group with a company, organization, or entity that may place this clinician or clinician group in a real, potential, or perceived conflict of interest situation.

**Table 3: Conflict of Interest Declaration for Clinician 3**

| Company | Check appropriate dollar range* | | | |
|---|---|---|---|---|
| | **$0 to $5,000** | **$5,001 to $10,000** | **$10,001 to $50,000** | **In excess of $50,000** |
| Add company name | | | | |
| Add company name | | | | |
| Add or remove rows as required | | | | |

* Place an X in the appropriate dollar range cells for each company.

Declaration for Clinician 4

Name: Dr. Rachel Goodwin

Position: Member, OH (CCO) Gastrointestinal Cancer Drug Advisory Committee

Date: 24-03-2024

☒ I hereby certify that I have the authority to disclose all relevant information with respect to any matter involving this clinician or clinician group with a company, organization, or entity that may place this clinician or clinician group in a real, potential, or perceived conflict of interest situation.

**Table 4: Conflict of Interest Declaration for Clinician 4**

| | **Check appropriate dollar range*** | | | |
|---|---|---|---|---|
| **Company** | **$0 to $5,000** | **$5,001 to $10,000** | **$10,001 to $50,000** | **In excess of $50,000** |
| Add company name | | | | |
| Add company name | | | | |
| Add or remove rows as required | | | | |

* Place an X in the appropriate dollar range cells for each company.