CADTH REIMBURSEMENT REVIEW

Patient and Clinician Group Input

dostarlimab (Jemperli)

GlaxoSmithKline Inc.

Indication: In combination with carboplatin and paclitaxel for the treatment of adult patients with primary advanced or recurrent endometrial cancer who are candidates for systemic therapy.

August 30, 2024

This document compiles the input submitted by patient groups and clinician groups for the file under review. The information is used by CADTH in all phases of the review, including the appraisal of evidence and interpretation of the results. The input submitted for each review is also included in the briefing materials that are sent to expert committee members prior to committee meetings.

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CADTH

Patient Input Template for CADTH Reimbursement Reviews

Name of Drug:	Dostarlimab (Jemperli)
Indication:	Dostarlimab in combination with carboplatin and paclitaxel for the treatment of adult patients with primary advanced or recurrent endometrial cancer who are candidates for systemic therapy.
Name of Patient Group:	Colorectal Cancer Resource & Action Network (**CCRAN**) in collaboration with the Canadian Cancer Survivor Network (**CCSN**).
Author of Submission:	Filomena Servidio-Italiano, President & CEO, CCRAN

1. About Your Patient Group

The Colorectal Cancer Resource & Action Network (CCRAN) is a national, not-for-profit patient advocacy group championing the health and wellbeing of Canadians touched by colorectal cancer and others at risk of developing the disease, by providing support, education and advocacy to help improve patient outcomes by way of longevity and quality of life. CCRAN has expanded its mandate to serve cancer patients outside of the colorectal cancer space through its HTA patient evidence submissions, educational events and advocacy initiatives. It collaborates with other tumour type patient advocacy groups to help achieve its expanded mandate because, collectively, it can achieve far more than it could working in silos. (www.ccran.org)

2. Information Gathering

To help capture the advanced and metastatic endometrial cancer patient perspective for this submission, CCRAN reached out to eighteen Canadian clinicians who treat the pathology via email to request their assistance identifying patients who had/have experience with Dostarlimab in combination with Carbotaxol in both the Mismatch Repair deficient (MMRd)/Microsatellite Instability-High(MSI-H) and Mismatch Repair proficient (MMRp)/Microsatellite Stable (MSS) molecular subtype patient populations. The email contained a patient poster (**APPENDIX C**) which clinicians could share with patients or their caregivers, who may be willing to participate in a telephone interview to provide their lived experience with not only the therapy under review, but their cancer diagnosis, treatment journey and endometrial cancer journey in general.

Each clinician was sent an initial email with three follow up emails, the first of which was sent out on **July 1, 2024, and the last of which was sent out on August 13th**. An outreach plea was also made to six U.S.-based gynecological oncologists on **July 15th, 2024**, via email, as well as to the International Gynecological (Gyne) Cancer Society and the Foundation for Women's Cancer. This outreach campaign resulted in four telephone interviews with metastatic endometrial cancer patients, three of whom had firsthand experience with the therapy under review (and whose tumours were identified to be MMRd/MSI-High). While the fourth patient had no experience with the therapy under review, she was eager to participate. Her cancer had been identified to be MMRp and she was passionate about representing the unmet needs of this subset of the endometrial cancer patient population, including the urgent need to access therapies such as Dostarlimab that had been proven, according to the literature, to improve outcomes in patients such as herself. An additional two interviews were conducted with clinicians who were also eager to participate and speak to the cancer journeys of the MMRp/MSS endometrial patient population whom they treat valiantly and intimately every day. **Respondents E** (gynecological medical oncologist) **and F** (gynecological oncologist) provided thoughtful and compelling input as they treat the metastatic and advanced endometrial cancer patient population, respectively. Their input reflects the perspectives and the lived experiences of the patients and caregivers they have treated throughout their practices and was secured to ensure this submission is well balanced and informed for this kind committee's deliberations. In particular, the Clinicians provided valuable perspectives for the MMRp/MSS patients whom they treat, and with whose treatment journeys they are well acquainted. The qualitative data secured from the six interviews is summarized and represented entirely in **APPENDIX A,** which is attached and will serve, for the most part, as the basis for this qualitative submission, in addition to the survey findings furnished by CCSN, as referenced below.

Finally, the Canadian Cancer Survivor Network (CCSN) produced and circulated a survey (**See APPENDIX B**) whose findings are being weaved throughout this submission. The survey was launched on **October 26, 2023, and closed on November 8, 2023**. The survey findings reflect the perspectives of the endometrial cancer patients who responded to the survey. While none of the respondents had firsthand experience with the therapy under review, the findings do reflect the insights, perspectives and values of the patients' experiences with respect to the diagnosis of endometrial cancer, disease experience and experience with respect to therapeutics currently approved to treat the pathology. Six (6) patients responded to the survey, all of whom reside in Canada [Nova Scotia (1), Ontario (2), Alberta (1), and British Columbia (2)]. The disease stage ranged from Stage Ib to Stage IVa as can be found according to Qs 2 and 6 in the survey.

3. Disease Experience

As the most common gynecological malignancy in Canada[1], endometrial cancer poses a serious health burden, especially in the advanced and metastatic settings. Two of the four interviewed patients were astonished to have discovered from their care team or their own research

efforts that not only is endometrial cancer of greatest incidence among the gynecological cancers, but it is also the gynecological cancer whose incidence is increasing in Canada (**Patients B & C**).

"….and to learn that this was the most popular gyne cancer that was on the rise, well that just floored me!" **Patient C**

Patients with early-stage disease can be treated with surgery, possibly in conjunction with chemotherapy, hormone therapy or radiation therapy, to achieve better results. However, treatment options are limited, and the overall prognosis is poor among patients with advanced or metastatic disease, creating a large unmet need in this setting. In particular, for the Mismatch Repair proficient (MMRp)/Microsatellite Stable (MSS) patient population who, according to our clinician input, account for approximately 70% of the endometrial cancer patient population, the unmet need is profoundly and overwhelmingly palpable for they have been in need of effective and targeted therapeutics for decades. Molecular subtypes can be identified by tumour MMR immunohistochemistry testing which is a relatively inexpensive and easily interpretable standard of care test for endometrial cancer.

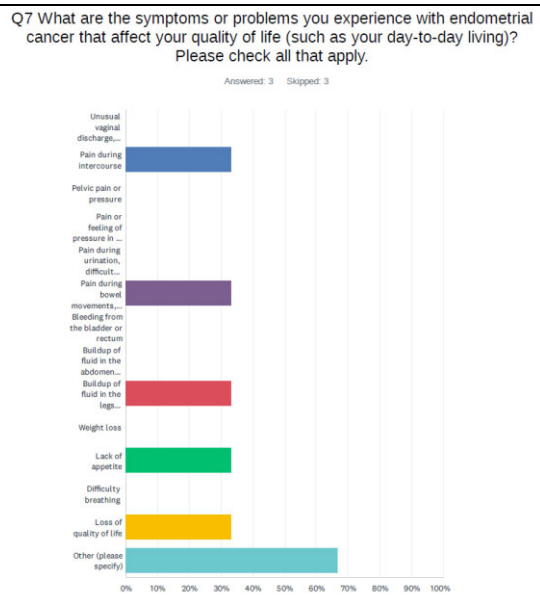
Most women with endometrial cancer will present with abnormal bleeding, irregular cycles and/or excessive bleeding in the premenopausal female, or any bleeding in the post-menopausal setting. In the advanced disease setting, women may complain of pelvic and abdominal discomfort, bloating, presence of a mass, gastrointestinal or genitourinary symptoms, or constitutional symptoms. According to the qualitative data captured in **APPENDIX A,** three of the four patients (**Patients A, B, and D**) had been experiencing post-menopausal bleeding for quite some time. And **Patient D** had experienced additional symptoms consistent with endometrial cancer that included:

- Low abdominal pain
- Watery discharge
- Increased urinary frequency
- Back pain

Patient C was delivered her **Stage IB** endometrial cancer diagnosis due to an incidental finding at the age of 53 years, but she eventually progressed to **Stage IV MSI-H disease**.
Patient A was diagnosed with **Stage IV MSI-H** endometrial cancer at the age of 84.
Patient B was originally diagnosed with **Stage I** endometrial cancer, but she progressed quickly to **Stage III MSI-H** disease at the age of 52 and eventually to **Stage IV**.
And finally, **Patient D** was diagnosed with **Stage IV MSS** endometrial cancer at the age of 63.

Three of the four patients (**Patients B, C and D**) expressed genuine, significant frustration and profound disappointment over their original symptoms whose cause could not be determined in a timely manner (ranging from months to years), despite repeated attempts and significant efforts on behalf of patients to access diagnostics to help identify the cause of their symptoms. Patients believe the lapse in time contributed to their disease progression leading to an eventual diagnosis of advanced or metastatic stage disease.
"***The entire process took too long. I did everything I could to obtain a timely diagnosis, but it was to no avail. The system failed me despite my best efforts, and I am a physician. What more could I have done***?" **Patient D**

CCSN's survey findings (**APPENDIX B**) clearly demonstrated the impact of the disease on the patient's day-to-day activities and ultimately their quality of life. **Q7** of the survey asked" "*What symptoms or problems do you experience with endometrial cancer that affect your quality of life?"*



Survey respondents selected the following symptoms or problems that impact their quality of life in their day to day living when undergoing the endometrial cancer journey:

- **Pain during intercourse,**
- **Pain during bowel movements, difficult bowel movements, or blood in the stool,**
- **Buildup of fluid in the abdomen (ascites),**
- **Lack of appetite**
- **Loss of quality of life**

A patient also provided the following open-ended reply:
"***Tired when I get up, lack of stamina***".
The disease clearly induces symptoms that impact the patient's day to day living and compromises quality of life.

Patient D shared that she had struggled with her cancer-induced symptoms for years: she endured abdominal and back pain, vaginal discharge, and increased urinary frequency, all of which had been brought to the attention of several physicians who did very little to help address those symptoms in terms of definitively determining causation.

"***For a long time, I felt as though I failed my family and myself. When I was in a more objective frame of mind, less emotional, I felt as though the system failed me, not the doctors, but the system that works through guidelines. Each doctor did what they were required to do through the guidelines. And that's why at this point, it is important to advocate on behalf of those who are showing less robust results for the MMRp in comparison to the MMRd patient population***." **Patient D**

Respondents E (gynecological medical oncologist) **and F** (gynecological oncologist) also provided input through telephone interviews, as they both treat the metastatic and advanced endometrial patient population, respectively. Their input reflects the perspectives and the lived experiences of the patients and caregivers they have treated throughout their practices and was secured to ensure this submission is well balanced and informed.

According to **Clinician E**, metastatic patients will typically present with lung and/or liver metastases, may have changes in their blood work, and may have some form of bowel dysfunction, after having been previously treated for the primary tumour some 6-12 months ago. This is not surprising to medical oncologists, who are expecting this patient population to progress because of the nature of the disease itself and the ineffective nature of the therapeutics currently approved to treat advanced stage disease**. Clinician F**, on the other hand, described the presentation of advanced stage disease, as she speaks to the most commonly experienced symptoms:

"***Vast majority of patients present with bleeding and tend to bleed early in the trajectory of the disease and certain patients do not bleed but some misunderstand the significance of bleeding; others have pain, others present with metastatic disease with pain in abdomen, and chest symptoms and lymph nodes in groin. Pain is indicative of advanced disease…..20% account for stage III or IV, they need adjuvant treatment too which is Carbotaxol. But in these patients, the disease comes back, and patients survive only 3 years…. there is good evidence from the Ruby trial to, therefore, add Dostarlimab to Carbotaxol for MMRd disease accounting for 30% of patients giving them a chance of cure at 4x. We have evidence also in MMRp patients although the magnitude of difference isn't as robust, but it also makes a substantial difference to give Dostarlimab with chemotherapy for these patients who account for 70%."***

The four interviewed patients articulately and vividly described the toll a diagnosis of advanced/metastatic endometrial cancer takes on the caregiver or family. The diagnosis can be equally frightening for the caregiver, who is typically the spouse, but can be anyone – a family member, friend or loved one. The caregiver may take on many roles in the course of the patient's journey. They will assume the role of medical translator, information specialist, transportation service, housekeeper/meal preparation, financial advisor, psychosocial support, and so much more. Quite often the caregiver's function is overshadowed or undervalued; in large part because the focus is typically on the patient, thus discounting the essential role played and meaningful contribution delivered by the caregiver. Our interviewed patients painfully described the stress and debilitating anxiety a caregiver undergoes once a diagnosis of advanced or metastatic endometrial cancer is delivered to the family. They explain:

"***It has certainly scared them like it scared me……they have had to take time off of work to take me to appointments and chemo. They are the ones helping me with understanding information. I have a sister who is helping me too. My kids are the ones bearing the burden and their lives have been disrupted in so many ways. I can't begin to tell you."*** **Patient A**

"***Ummmm, I think they have been in shock. I have 2 daughters who are expecting babies, but they are worried about me, but it has been so stressful for them. They want to be excited about their upcoming deliveries, but totally worried about me. I don't know how to help them while I am trying to help me***." **Patient B**

"***My husband went with me to every appointment and treatment. And this was at the expense of his work. My young son was overseas and came back for me. Young people travel but it is definitely a financial cost for us because he has yet to establish himself. Definitely the fact that I am off work, as a physician, I am now on disability, and I am definitely grateful now, but I don't know when I will go back***." **Patient D**

With respect to the caregiver/family, **Clinician F** reinforced the emotional and devastating toll the disease immediately imposes upon the family as they shared the following:

"***I will share with you that if the patient's symptoms are not well tolerated, and the cancer is not controlled this is devastating to the family and they have a difficult time coping. Things like bowel blockages, ascites, symptoms that behave like ovarian cancer in other words, like pleural effusion, ureter obstruction, it can be not only debilitating but difficult to cope with for the patient and the family. It makes the journey almost intolerable, and I see this firsthand how they suffer. This is a difficult journey."*** **Clinician F**

4. Experiences With Currently Available Treatments

The patient input highlighted the treatments that are currently available and being accessed for the management of endometrial cancer. The interviewed patients who were diagnosed with advanced or recurrent disease shared they have limited treatment options. If diagnosed with an early-stage disease, patients will undergo surgery to remove the uterus (and perhaps the cervix), fallopian tubes and regional lymph nodes. **Patient C** shared that radiation therapy was accessed to help kill her cancer cells after her surgery. And hormonal therapy may be prescribed to block cancer growth, as was the case for **Patients A and B**. Carboplatin in combination with paclitaxel (Carbotaxol) are standard chemotherapy treatments indicated for endometrial cancer in both the adjuvant setting and first line treatment of metastatic disease. These therapies, in particular Carbotaxol, are associated with treatment induced toxicities that compromise patients' quality of life and fail to extend patients' longevity in a meaningful manner.

The CCSN survey results (**Q17**) captured the following treatment-induced toxicities from patients' current treatments, with neuropathy having been selected by most users. Four patients responded to the question, **three** of whom experienced treatment-induced neuropathy:

- Neuropathy (3)
- Fatigue (2)
- Changes in sexual functioning (2)
- Dryness, itching, tightening, and burning in the vagina (2)
- Fluid Retention (1)
- Nausea (1)
- Constipation (1)
- Chemo brain (1)

Q20 of the survey asked patients how well they were managing at this stage in their treatment with respect to surgery, radiation therapy and chemotherapy. The distressing replies were in respect of chemotherapy:
"***Was tough; much nausea and constipation."*** ***"Affects my thinking, loss of stamina, fatigue***."

Our interviewed patients provided thoughtful input regarding their treatment journeys. **Patient A**, who is currently 84 years of age, was diagnosed at the age of 76 after having undergone a D&C because she presented with excessive postmenopausal bleeding. A hysterectomy then ensued. Her disease was in remission through to December 2023, when hip and spinal pain alerted her physician to order a CT scan which confirmed metastatic endometrial cancer recurrence for which she was prescribed Dostarlimab in combination with Carbotaxol to treat the lung and spinal (coccyx) metastases.
After **Patient B** experienced vaginal bleeding at the age of 52, she had a long wait time to receive a diagnosis of endometrial cancer - well over 9 months. A D&C on January 31, 2024, eventually confirmed the stage I diagnosis but the hysterectomy indicated otherwise – it detected the invasion of regional lymph nodes which upstaged her disease to a stage III, and she was then identified to have Lynch Syndrome. This qualified her for Dostarlimab + Carbotaxol every 3 weeks. Eventually, however, her disease did reveal metastatic activity.
At the age of 53, **Patient C** was diagnosed with Stage IB, Grade 3 endometrial cancer which she had surgically resected, and she also underwent 25 cycles of adjuvant radiation therapy. One year later, in January 2024, she was diagnosed with recurrent, metastatic MSI-H disease to the thyroid and lungs for which she was prescribed Dostarlimab + Carbotaxol which she commenced on April 5, 2024.
At the age of 63, **Patient D** was initially diagnosed with Stage 3A MMRp endometrial cancer but eventually learned that her surgical pathology report did reveal omental involvement, and as a result, her disease has been reassessed as stage IV. She underwent surgical resection in February 2024 and started Carbotaxol therapy on March 5th, 2024 which ended on July 9, 2024. She sadly did not access Dostarlimab for her MMRp disease and shared the following:
"…***Each doctor did what they were required to do through the guidelines. And that's why at this point, it is important to advocate on behalf of those who are showing less robust results for the MMRp in comparison to the MMRd patient population. However, every life matters and my life matters. In the US, immunotherapy (Dostarlimab) is now being recommended in first line in combination with chemo for women such as myself for MMRp advanced and metastatic patients. So, this interview is really important to me to help accomplish something meaningful***." **Patient D**

Patient D shared her cycles of Carbotaxol were "*nothing terrible*". According to her, she "*did ok*". However, she did experience some side effects that included low mood, malaise, poor stamina and neuropathy which she continues to experience in her toes to date. **Patient C** reported experiencing radiation-induced diarrhea and skin irritation which she states was minor in comparison to what other women have experienced.

Our interviewed clinicians shared that "***Carbotaxol is tolerated quite well***" (**Clinician E**). According to **Clinician E**, in the metastatic setting, neuropathy is one of the more frequently experienced side effects, however, resistance does eventually set in. There is a subset of the patient population in whom desensitization is required because an allergy is present from the beginning or eventually develops to chemotherapy. **Clinician E** did comment on Pembrolenva being administered in the metastatic setting: patients do experience issues with respect to elevated blood pressure early on and the fatigue is quite debilitating, in addition to the bone pain, which can be quite traumatic. Lenvatinib can also bring on significant diarrhea according **Clinician E.** The Pembrolizumab is "ok". In the advanced setting, **Clinician F** spoke to the toxicities of Carbotaxol such as hair loss, neuropathy, and gastrointestinal issues which patients are happy to tolerate in the face of their adversity, in the hope of securing a favorable outcome. **Clinician F** spoke to the sadness of it all though, knowing that the disease recurs so quickly in this patient population, after one year typically, from the date of the patient's diagnosis, shattering their hopes for a lengthy disease-free time. Which is why **Clinician F** felt compelled to share:

"***Adding Dostarlimab, will not increase side effects but will increase the longevity in both MMRd and MMRp disease. And seeing that the MMRp patients are desperately in need of something that is effective, safe and promotes quality of life, well this is really good for them. Because the unmet need is in the advanced stage disease for MMRp and in the metastatic setting for MMRp endometrial cancer***." **Clinician F**

Clinician F's invocation aligns nicely with **Patient D's** plea for access to Dostarlimab to treat her MMRp disease. **Patient D** was not able to access the immunotherapy in her province, knowing fully well that it is available to other MMRp endometrial cancer patients in other international jurisdictions. There continues to be a significant clinical unmet need in patients with MSS or MMR proficient advanced endometrial cancer in Canada, indicating the need for novel therapies that delay disease progression, improve overall survival and could very well reduce hospitalization rates for this subset of the patient population, a point that was well articulated by **Clinician F**:

"*….But there is evidence to support the use of Dostarlimab. As a civilized society, we treat people with the most effective treatment with much evidence that will make a difference, and it is not worth waiting for this effective, evidence-based therapy…. The point to be made here is if we use the proper treatment, patients who have roles to play in their lives, such as mothers, sisters, daughters, well, if they are not sick then they can continue to make contributions in their lives. I have patients who have been able to continue to make these contributions or play these roles because of immunotherapy such Dostarlimab, especially Dostarlimab. They are not in the ER or hospital. They are living good lives. We as gyne oncologists also operate so I have a limited number of beds available to me in our ward, so if you have someone who is so sick due to chemo, for example, they are*

***occupying a bed that would otherwise not be available to me to a surgical patient so that somebody who needs that bed to have surgery and be cured outright, well, it's taking away – it's what we refer to as opportunity costs.*" Clinician F**

5. Improved Outcomes

Q22 of the **CCSN survey** asked, "***Which of the following issues would you hope that a new treatment would address to manage your disease?***" and then asked respondents to rate the options from **most important (1)** to least important (7).
Five respondents provided their input and rated the seven issues according to what they believe is most important or meaningful in their endometrial cancer journey. The attribute that was selected by **60%** of respondents was "**Prolong Life**" which speaks to the patients' desire to have their life extended in a meaningful manner by the therapeutics they are having administered for the management of their disease. **40%** of respondents also selected **"Provide a cure**" which aligns well with the patient's need to access therapies that promote hope for the future and longevity.

	1	2	3	4	5	6	7	TOTAL	WEIGHTED AVERAGE
Maintain quality of life	20.00% 1	20.00% 1	0.00% 0	20.00% 1	0.00% 0	0.00% 0	40.00% 2	5	4.20
Delay onset of symptoms	0.00% 0	25.00% 1	25.00% 1	0.00% 0	0.00% 0	25.00% 1	25.00% 1	4	4.50
Access to a new option for treatment	25.00% 1	25.00% 1	25.00% 1	0.00% 0	25.00% 1	0.00% 0	0.00% 0	4	2.75
Reduce side effects from current medications or treatments	20.00% 1	0.00% 0	40.00% 2	0.00% 0	40.00% 2	0.00% 0	0.00% 0	5	3.40
Ease of use	20.00% 1	0.00% 0	20.00% 1	0.00% 0	0.00% 0	0.00% 0	60.00% 3	5	5.00
Prolong life	60.00% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	40.00% 2	5	3.40
Provide a cure	40.00% 2	20.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	40.00% 2	5	3.60

Qs 23, 24 and 25 of the survey asked: "*..if the respondent were to consider taking a new therapy for their cancer, what severity of side effects would they be willing to tolerate to extend survival by **2, 6 and 12 months** respectively after having been told there is no other available treatment for them*". Five patients responded and for each incremental increase in survival benefit, the weighted average did most certainly improve. Respondents provided the following input for 2-, 6- and 12-month survival benefit respectively, corresponding with weighted averages of **5.2, 6.4 and 6.8**, indicating patients are prepared to tolerate treatment induced toxicities for a survival benefit:

1	2	3	4	5	6	7	8	9	10	TOTAL	WEIGHTED AVERAGE
0.00% 0	20.00% 1	20.00% 1	20.00% 1	0.00% 0	0.00% 0	20.00% 1	0.00% 0	0.00% 0	20.00% 1	5	5.20

1	2	3	4	5	6	7	8	9	10	TOTAL	WEIGHTED AVERAGE
0.00% 0	0.00% 0	0.00% 0	40.00% 2	0.00% 0	20.00% 1	0.00% 0	20.00% 1	0.00% 0	20.00% 1	5	6.40

1	2	3	4	5	6	7	8	9	10	TOTAL	WEIGHTED AVERAGE
0.00% 0	0.00% 0	0.00% 0	20.00% 1	20.00% 1	20.00% 1	0.00% 0	0.00% 0	20.00% 1	20.00% 1	5	6.80

All interviewed patients provided their perspective on the improvements (**Q24**) they would wish to see associated with a new drug therapy – improvements they believe are currently not available with standard of care chemotherapies for the management of advanced or metastatic endometrial cancer. They passionately expressed the following: a desire to access a therapy that would promote a good quality of life while effectively regressing their disease.

"***I think the survival rate should be higher. If the chance of survival is higher, because don't we all want that? And the side effects should be eliminated, then it should increase our chance of survival without bad side effects***." **Patient C**

Patients focused on being able to access a drug therapy that could be free of debilitating side effects, allowing them the ability to live their lives with some degree of normalcy. **Patient A** also emphasized the need to access therapies that can be easily administered in the comfort of her own home: an oral agent that would reduce the number of visits to the cancer centre. In her words:
"***And if we could take that drug via pill, as opposed to going to the cancer centre, cuz it's so time consuming that would be great***."
Patient A

All patients spoke of the importance of curative therapies becoming available for this patient population because of its current dismal survival rate. They look to Dostarlimab with great hope and the meaningful response it can provide for both the MMRp/MSS and MMRd/MSI-H patient subsets. **Patient D** shared:

"***I would like to see a drug therapy to be implemented as soon as evidence comes along or at the discretion of clinicians regardless of the guidelines existing, to have an individual approach for rare and advanced diseases (like endometrial cancer). I would like it to cure the disease because the rest is in between. Doesn't everybody want that?"*** **Patient D**

Furthermore, all three patients who accessed Dostarlimab maintain the therapy currently possesses most of the desired improvements mentioned, (oral agent notwithstanding), and were extremely grateful to have been able to access this therapy (***Q25***). According to their explicit and detailed input, it has prolonged their life with minimal to no side effects, promoting good quality of life. Their lives have been truly ameliorated, such that they have been able to engage in life's activities, spend quality time with friends and family, permitting them the freedom to "*living life again*". In their own words, patients provided the following input regarding the current therapy (Dostarlimab + Carbotaxol) possessing the desired improvements:
"***Yes, it definitely has no side effects which is terrific. And who knows, maybe it will keep me alive for a long time.*"** **Patient A**
"I would say yes now. It's so hard to tell because I am doing it in conjunction with chemo, but I have the extra fight for punch with Dostarlimab and I believe it is achieving greatness for me because it is targeting my specific cancer." **Patient B**
"*I think so yes…. I am so grateful. I just need my pancreas to cooperate. And I feel ok otherwise. One step at a time."* **Patient C**

6. Experience With Drug Under Review

Qs 12-26 of APPENDIX 1 captured the treatment-related experiences for three interviewed Canadian patients who have firsthand experience with Dostarlimab (**Patients A, B and C**, all of whom were diagnosed with MSI-H disease). **Clinicians E and F** were kind enough to provide input for the MMRp/MSS patients whom they treat, and with whom they are well acquainted, to help balance this submission to represent the unmet needs of a highly vulnerable patient population in need of effective and less toxic therapies.

Patient A accessed Dostarlimab + Carbotaxol through the cancer centre. Her treatment commenced on January 19, 2024, as first line therapy for the treatment of her metastatic endometrial cancer. Once she completed the six cycles of Carbotaxol, she was delighted to be permitted to continue with the Dostarlimab portion of the protocol. The only side effect she claims she has experienced from the Dostarlimab at the age of 84 is fatigue. She maintains she has experienced no other side effects. In her words, "***it has been really good being on this treatmen***t". She rated the therapy an **8 or 9** out of a possible 10 because "***I can do everything but walk like I used to. I still have a pretty darn good life***." Her pain has resolved completely, she has experienced a lovely response to the therapy and her "***doctor is very pleased with my response to the therapy***." She also speaks to the shorter amount of time in the chemo chair in the infusion clinic which is a "***benefit to me so I can go home earlier now that I am no longer taking the chemo***!" She was so happy that she accessed this therapy because it has bought her time with her children and grandchildren. She shares: "***Time is precious, and it is a commodity that has no price tag, it cannot be defined.***" She also shared what Dostarlimab has allowed her the opportunity to fulfill in her life: "***…I don't think I would be here today, and I can do extra things that I don't think I would be able to do were it not for the immunotherapy. …One grand daughter just graduated from university, and I believe I would have missed that. She was out of town! And another grand daughter is graduating next year, and I believe I will be able to attend, she is located in BC! I am thinking of going to Manitoba, my hometown, to join my sisters this summer and I wouldn't be able to do that were it not for immunotherapy. I credit Dostarlimab for my ability to travel and spend quality time with my family***."

Patient B believes she accessed Dostarlimab + Carbotaxol through a special access program but is not totally certain. She received her first treatment on May 24, 2024, in the first line treatment for the management of her MMRd disease that was also identified as Lynch Syndrome. As of her interview date, July 30, 2024, the patient had received 4 cycles of the protocol and had experienced no side effects which is why she rated her quality of life while undergoing Dostarlimab + Carbotaxol a **9 or 10** out of a possible 10. She added: "**knowing that there is something being done, absolutely makes you feel better**." She shared that on May 16th, 2024, one week prior to starting therapy, an MRI and CT scan captured some lung nodules (CT) and lymph nodes (MRI) before starting the Dostarlimab with chemo. However, after completing just **3 cycles of Dostarlimab and chemo**, the PET/CT ordered by her oncologist showed no evidence of disease! There had been complete resolution of disease in her body. All lung nodules and lymph node involvement had disappeared! She was absolutely elated. She shares: "…***this (therapy) has clearly proven to be extremely important and effective for me! It can be for others too!... I wanted 5 years more life, and I think the immunotherapy is a huge component in helping me achieve that and see the birth of my 2 grandchildren with whom I will be able to see and spend time with, enjoy and love and nurture. I am so grateful but more importantly, I think I can now push the envelope with Dostarlimab to ten years. I think I can actually be cured of this disease because of this therapy."***

Patient C accessed Dostarlimab + Carbotaxol through a special access program. She started the protocol on April 5th, 2024, through first line treatment for the management of her MSI-H disease. As of the date of her interview, she had completed 5 cycles out of a possible 6, after which point, the chemotherapy would be stopped, and the immunotherapy would continue every 6 weeks for two years. The side effects experienced from the treatment are leg pain, gastrointestinal issues, and a small rash on her knees. She rates her quality of life on this treatment as a **7 or 8**. CT has confirmed response to this treatment after cycle 3. The disease in her thyroid has reduced by 85% and the lung nodules have reduced by 70%. In **Patient C's** words: "***It's really working for me. I am so happy with the results***". She has had to take a 3-week break from the treatment because her lipase and amylase levels are elevated. Hence, the treatment cessation will allow those levels to come down and she will eventually resume therapy. She shares: "***As a researcher, I believe in the data so yes, this therapy gives me hope."*** **Patient C** shares what Dostarlimab has allowed her to continue to do in life: "***I continue to work as a researcher; I work in the morning and take afternoons off. I do meditation yoga. I exercise and take walks. I live alone so I take***

care of my home, vacuum, I take care of my pet, I do household chores, and I do everything for myself at home. I have gone to my friends for dinner at their place. This is all about living life while on the therapy. "
She goes on to say on behalf of all endometrial cancer patients:
"…***we don't want to die in 2 months. The chance of extending survival is important while enjoying life. So, let's get this approved for everyone, not just MSI-H women. We all deserve it. Every woman deserves a fighting chance at life when diagnosed with endometrial cancer…. but getting the immunotherapy to women is imperative. This therapy works. So, let's approve and fund it for all. We need to ensure it is available for all, not just through special access***."

Interviewed patients maintain that **Dostarlimab + Carbotaxol** has delivered a remarkable response wherein their disease has regressed significantly in addition to having provided them with an excellent quality of life because Dostarlimab has fewer treatment-induced toxicities relative to chemotherapy; and when administered as a single agent every 6 weeks post chemotherapy use, it has a considerably shorter infusion time, which patients highly welcome. These interviewed patients were identified to have MMRd/MSI-H molecular subtype accounting for approximately 30% of the endometrial cancer patient population. It is critically important we represent the balance of the endometrial cancer patient population perspectives, the **70%** who are significantly, clinically underrepresented because of their unmet need – the MMRp/MSS molecular subtype. We wish to address this group in the next section.

7. Anything Else?

There is an urgent, significant clinical unmet need in patients with MMRp/MSS advanced/metastatic endometrial cancer in Canada. This clearly indicates the necessity for novel therapies that delay disease progression, improve overall survival and reduce ER visits and hospitalizations from treatment-induced toxicities and adverse events. Seeing that this molecular subtype accounts for approximately 70% of the endometrial cancer patient population (according to our clinician input), it behooves us to work not only passionately, but fiercely and swiftly, to move the needle forward to equip our clinicians with the effective and less toxic therapeutics that will help improve outcomes for this endometrial cancer patient population.

To help secure the perspectives of this underserved subset of the patient population, **Clinicians E and F** provided their valuable perspectives for the MMRp/MSS patients whom they treat, and with whose treatment journeys they are well acquainted. **Clinician E**, a gynecological medical oncologist, emphatically stated that adding Dostarlimab to Carbotaxol does not generally contribute to the overall toxicity load. **Clinician E** shares: "…***thyroid dysfunction was experienced…. But they actually have few issues with immunotherapy. We are super good at giving IO, so we jump on things fast…..Diarrhea is the only issue in addition to the thyroid dysfunction, so if you stay on top of those, it has been good. Patients are tolerating the Dostarlimab really well. …It's always the chemo…it is not more burdensome***." **Clinician E** does distinguish between chemotherapy naïve patients and those patients who have previously accessed Carbotaxol in the adjuvant setting, recur and are, therefore, required to access it again in combination with Dostarlimab. The performance status in these latter patients may not be at par with the former patients. Endometrial cancer patients who have previously received toxic chemotherapies may be somewhat physically compromised. **Clinician E** accordingly rates the quality of life of these two patient groups who access the protocol as a **9 or 10** vs a **6** out of a possible 10. They did state that once the chemotherapy portion of the protocol is eliminated and confined to the immunotherapy alone, the patient's quality of life does improve in the second group: "***Once the patient does respond to the therapy, after 3 months you will know if they are, most of the immunotherapy side effects will be well under control and they will have no IO problems later on and when you pull the chemo and left with just IO, you should get them back to pretty much baseline quality of life***."
Clinician E shared that no patient has shared regret accessing the immunotherapy, quite the opposite. Patients are delighted to have been able to access Dostarlimab. Patients feel as though they are on "***the state of the art therapy and, therefore, providing hope***" …."***You have to have hope because it's an absolutely unbelievable journey to undergo, to be poisoned every 3 weeks. You are manipulating your body to induce your immune system to attack itself and if it works, it's great, but if it produces damage, it can be painful, on more than just one level. So, you have to have hope along the way***."
In terms of an improvement to currently existing drug therapies: **Clinician E** would like to see the introduction of oral agents because "***chair time and hours spent in chairs is difficult…and that is a massive burden on our healthcare system so if we can relieve it, that would be great***." When speaking of the benefits of Dostarlimab, **Clinician E** emphatically acknowledged that it may prevent a patient from proceeding to a further line of therapy because in addition to being highly effective, it possesses fewer toxicities (when compared to chemotherapies), can be administered every 6 weeks which is highly welcomed by patients, and it has a shorter infusion time (30 minutes). In **Clinician E**'s humble opinion, Dostarlimab is a "***much easier drug to use***". **Clinician E** made a final plea regarding the use of Dostarlimab in the MMRp/MSS patient population. She maintains there is a huge unmet need in these patients, as they currently do not have any effective treatment options once platinum resistance sets in. She sees significant loss of quantity and quality of life in women, most certainly in their 50s and 60s who are primary caregivers to not only their children, but their parents as well. These are contributing members of society fulfilling significant roles, gainfully employed women, but soon to be robbed of their livelihood and life. "***The decision to access Dostarlimab + Chemo for which there is evidence to support its utility should be left to the clinician and their patient…. without Dostarlimab, patients will rapidly deteriorate with chemo alone or to their less effective agents, leaving a hole in their family life. These women will die with an IV in their arms – we will not save any health care resources by not treating them: on the contrary, we will incur more healthcare resources by having them go to the ER, increase hospitalizations, treatment-induced toxicities, and as a result, suffer the burden of caring for them in our clinics and centers across Canada due to ineffective and toxic treatments. Please issue a positive funding recommendation."***

Clinician F, a gynecological oncologist, shared that they have observed Dostarlimab-induced reactions in patients that include autoimmune reactions such as skin rashes, pneumonitis, colitis, arthritis, thyroid dysfunction but the main organ involved is the skin. While rare, it does happen. She shares: "...***and the key is to be alert to work with the patient to treat promptly. Because that can make the difference in the world to getting the reaction under control in a timely manner and improving quality of life so that the patient can stay on the***

immunotherapy." She rates the patients' quality of life while on the protocol based on patient feedback as an **8 most of the time and some 9**, especially if there is a symptom they can intersect successfully. **Clinician F's** patients access the therapy in the adjuvant or recurrent setting. According to **Clinician F**, patients present with bowel or ureter obstructions which can be quite painful. She shares that once they administer the Dostarlimab, the tumours "***melt away and they function so well. I have a patient who had a dance school and then reopened it because of Dostarlimab. Another woman had a jewelry shop who is now back at work with her husband because of Dostarlimab. Pain and other symptoms disappear because of this immunotherapy.***" Admittedly, according to **Clinician F**, if severe immune reactions are experienced by patients, then Dostarlimab is discontinued, although steroid therapy will be administered to help address the immune reactions. However, she does mention that the efficacy of Dostarlimab continues well after its cessation, approximately 7 months after it has been discontinued. Permanent discontinuation is rare according to **Clinician F**, only in the setting of severe and life-threatening circumstances. **Clinician F** maintains that the Dostarlimab has been easier to use than other approved therapies: "***it's a half hour infusion compared to 8 hours per day of chemo. Dostarlimab is literally a walk in the park compared to everything else***." She shares that "***there are very many women who are alive today because patients were able to access Dostarlimab. Without it, they likely would not be here, and they are sincerely happy and grateful. They understand what it means to have been able to access this immunotherapy***." She also shares what patients have been able to accomplish because of their improved quality of life and longevity afforded by Dostarlimab. Patients were able to see their children graduate, marry, spend time with their grandchildren, go on safaris, travel to Europe, done things that they could not have otherwise imagined while being on cancer treatment. "***We give Dostarlimab and off they go. They were able to get this infusion to go off for 6 weeks and do wonderfully meaningful things with their lives. And they are still here today***." She wished for this submission author to include the following statement: "***Adding Dostarlimab will not increase side effects but will increase the longevity in both MMRd and MMRp disease. And seeing that the MMRp patients are desperately in need of something that is effective, safe and promotes quality of life, well this is really good for them. Because the unmet need is in the advanced stage disease for MMRp and in the metastatic setting for MMRp endometrial cancer.***" She further states: "***When there is level one evidence that can make a difference, this can bring hope and provide a truly significant difference. It's devastating to learn of this diagnosis. But there is evidence to support the use of Dostarlimab. As a civilized society, we treat people with the most effective treatment with much evidence that will make a difference, and it is not worth waiting for this effective, evidence-based therapy.***"

Finally, **Patient D** who is herself an MMRp metastatic endometrial cancer patient, was unable to access Dostarlimab in combination with Carbotaxol. She has a plea she would like to make to this kind committee. She believes Dostarlimab should be made available to patients such as herself in frontline therapy because it has been shown to be effective in preventing disease progression and increasing survival in studies in the management of advanced and metastatic MMRp endometrial cancer. According to her, patients with MMRp disease make up the majority of endometrial cancer patients who "***have been looking for solutions, more options, hope and we finally have it. I needed this option but wasn't offered it. So now, in the event I recur, and I know I will, I will make sure I get it, even if I have to pay for it. This is a true innovation and as a physician, I recognize that metastatic endometrial patients should be afforded this innovation. Please fund this therapy for the majority of endometrial cancer patients who have been desperately waiting for another effective treatment option that has been sorely lacking for decades***."

A personal plea from the author of this submission: "As a caregiver to a family member who was afflicted with and recently succumbed to metastatic MMRp endometrial cancer, I have personally witnessed the unspeakable toll this devastating pathology assumes not only on the patient but on the entire family. It delivers no mercy and will assume the life of an innocent victim and its precious family in record time because of the lack of effective therapies currently available to treat this subset of the patient population. The patient and their family suffer horrific, unimaginable and unspeakable horrors whose ripple effects extend well beyond the healthcare system because these women are not only responsible for caring for their children, parents, parents in law, but are also overseeing highly successful businesses that benefit our Canadian economy and entrusted with the livelihoods of talented and skilled employees across multiple jurisdictions. My family member most certainly did die with an infusion catheter in her arm because it was her wish to avail herself of any therapeutic that could potentially extend her life, despite enduring debilitating toxicities, as she valiantly fought to stay alive to the very end. This is inhumane, especially in the setting of high-level evidence that exists to support the administration of an immunotherapy that can improve patient outcomes for the MMRp molecular subtype. As a caregiver, I am respectfully requesting and imploring that thoughtful and reflective consideration be granted to the review of this effective, life-extending, easily administered therapy in helping to support and treat all comers when diagnosed with advanced or recurrent endometrial cancer. It will most surely make a tremendously meaningful difference in the lives of endometrial cancer patients and their families. Please issue the recommendation we all desperately require for these patients."

If publicly funded, Dostarlimab + Carbotaxol would be an extremely important frontline/first line therapy for endometrial cancer patients regardless of their mismatch repair/microsatellite instability status. Broadening the patient eligibility will not only reflect a more inclusive approach to treatment but will ultimately improve patient outcomes and save healthcare resources as per the clinician input provided herein. This inclusivity approach represents a path toward progress and will help address the many needs of patients diagnosed with endometrial cancer: improved patient outcomes by way of extended progression free survival and overall survival, good quality of life, and shorter infusion time.

Funding the inclusion of Dostarlimab therapy aligns well with the patient perspectives captured within this submission. **We, therefore, strongly and passionately support and urge that a positive funding recommendation be issued for Dostarlimab for the treatment of adult patients with primary advanced or recurrent endometrial cancer who are candidates for systemic therapy.** We believe it aligns well with the identified patient's need for a new, effective, quickly administered, less toxic treatment option that can maintain a high quality of life for the patient. **Dostarlimab should become the new standard of care for the advanced/recurrent endometrial cancer patient population, which includes the MMRp/MSS molecular subtypes**.

1. CMAJ 2021 September 13;193:E1423. doi: 10.1503/cmaj.202731

Appendix: Patient Group Conflict of Interest Declaration

To maintain the objectivity and credibility of the CADTH reimbursement review process, 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

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

3. List any companies or organizations that have provided your group with financial payment over the past 2 years AND who may have direct or indirect interest in the drug under review.

Table 1: Financial Disclosures

Check Appropriate Dollar Range With an X. Add additional rows if necessary.

Company	$0 to 5,000	$5,001 to 10,000	$10,001 to 50,000	In Excess of $50,000
GSK			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: **Filomena Servidio-Italiano**
Position: **President & CEO**
Patient Group: **Colorectal Cancer Resource & Action Network (CCRAN)**
Date: **August 30, 2024**

APPENDIX A

DOSTARLIMAB (IMMUNOTHERAPY) + CHEMOTHERAPY: PATIENT & CLINICIAN INTERVIEW DATA

INTERVIEW QUESTION	RESPONDENT A PATIENT (MSI-H) STAGE IV	RESPONDENT B PATIENT (MMRd) STAGE III	RESPONDENT C PATIENT (MSI-H) STAGE IV	RESPONDENT D PATIENT (MMRp/ MSS) STAGE IV	RESPONDENT E CLINICIAN MED ONC	RESPONDENT F CLINICIAN GYNE ONC
PART A: DEMOGRAPHICS/INFORMATION GATHERING						
1. INTERVIEW DATE, TIME & METHOD	July 9, 2024 1:00 – 2:30 p.m. Telephone	July 30, 2024 1:00 – 2:30 p.m. Telephone	August 8, 2024 11:00 am – 12:30 p.m. Telephone	August 12, 2024 10:00 – 11:30 a.m. Telephone	August 19, 2024 9:30 – 10:30 a.m. Telephone	August 21, 2024 10:00 – 11:00 a.m. Telephone
2. PATIENT'S CURRENT AGE, AGE AT DIAGNOSIS, & GENDER	-84 years old -76 years old -Female	- 53 years old - 52 years old - Female	- 55 years old - 53 years old - Female	- 63 years old - 63 years old - Female	On behalf of Metastatic Endometrial Cancer Patients	On behalf of Advanced Endometrial Cancer Patients
3. CITY, PROVINCE	Edmonton, Alberta	Edmonton, Alberta	Edmonton, Alberta	Toronto, Ontario	Montreal, Quebec	Montreal, Quebec
4. A. MARITAL STATUS S/M/D/CL **B. CHILDREN**	Widow 2 children, and 2 grand daughters	Married 3 children: 31, 29 and 26 years and 2 grandchildren on the way!	Single No children	Married 2 Children: 39 and 32 years old and 2 grand children	On behalf of Metastatic Endometrial Cancer Patients	On behalf of Advanced Endometrial Cancer Patients
5. OUTREACH METHOD: (CANADIAN CLINICIAN, U.S. CLINICIAN, ETC)	Canadian Clinician	Canadian Clinician	Canadian Clinician	Canadian Clinician	Canadian Clinician (Gynecological Medical Oncologist)	Canadian Clinician (Gynecological Oncologist)
6. TREATMENT CENTRE	Alberta-based Cancer Centre	Alberta-based Cancer Centre	Alberta-based Cancer Centre	Toronto based cancer centre	Montreal-based Cancer Centre	Montreal-based Cancer Centre
PART B: DISEASE EXPERIENCE & EXPERIENCES WITH CURRENTLY AVAILABLE TREATMENTS						
7. A. WHEN WERE YOU FIRST DIAGNOSED WITH	"In 2016. I started to bleed from my vagina, just like a period so I went to a doctor who sent	"I was diagnosed on February 2nd, 2024. So, really in October 2022, an internal ultrasound was had,	"In August 2022. I thought I had a yeast infection, so I went to see my doctor and did an	"December 2023. I had endometrial hyperplasia and uterine fibroids and was followed up by	N/A	N/A

ENDOMETRIAL CANCER	me to a specialist and gave me a D&C and then had a hysterectomy and that's how I got diagnosed. I took pills from there, but I can't really remember."	and it showed nothing concerning other than a 10 mm uterine lining and the reason for the appt was that I had some heavy bleeding and no menopause. Then at that point, I had to wait for a gyne appt, so I waited for 8 months for that appt, and that was it. I saw the gyne and she wanted to put me on some strong progesterone pills to help shed the lining, but I was nervous to do that. I started it in September 2023 and then I had some heavy bleeding with that so then things were not settling down so in December in 2023 I had an ultrasound, and the lining had more than doubled by then. So, in January 2024 the gyne recommended a D&C to scrape out that lining and then	ultrasound, and the uterus was abnormal and performed a biopsy. The thickness was abnormal. That was in august of 2022. Then we had a hysterectomy in October 2022. Confirmed that it was stage 1B cancer. But it was a grade 3 cancer. Since there was some thing they saw in the nearby interstitial cells they did 25 cycles of radiation. Then I was good till February 2023. Everything was good. Then, during my annual checkup with ultrasound, in January 2024, found a nodule on the right of the thyroid, which required biopsy. It came back metastatic from endometrial cancer. There was one nodule that was positive in the thyroid. So, in March 2024, went to go see my care	a gyne for years. I had 3 biopsies for ten years and an IUD. Then my appt in 2019 took place but my follow-up never happened because if I didn't have symptoms, it didn't need to take place because of covid. Then when the offices reopened, if I didn't have symptoms, I wasn't required to go. I did have two conditions that served as a precursor to cancer, and I didn't request that the secretary ask the doctor to have me be seen. Then I had atypical cells in a pap smear in 2022 which went to Ontario health, where they work on the specimen. They interpreted it as possible aging and told me to repeat in one year. We agreed to repeat in 6 months. And it looked normal in May 2023. I was still		

		I was diagnosed with cancer of the uterus through the D&C. “	team (oncologist) and started Dostarlimab plus chemo (Carbotaxol) on April 5th. When I did my CT scan before starting immunotherapy, it identified nodules on the lungs. “	asymptomatic. I had low abdominal pain. From end of July 2023, I started having symptoms resembling urinary tract infection which I never had, and I did a urinary stick and I had blood in urine but was not something to proceed with. Then I had watery discharge in July – August 2023 then discomfort in abdomen and back. But beginning of September 2023, it was brownish discharge. Which required pads. I went to family doctor in September 2023. Then the smear was taken and lost because they switched to a new EMR system accounting for the lost sample and a second smear was done and it was negative for infection. From this point, I was referred		

				to another specialist and they wanted an ultrasound for me because I had significant discomfort. And I had urinary frequency too. Then they did it and saw a polyp and I was seen quite quickly by the gyne and I had a D&C and in December 2023 I was told that I had an aggressive tumor. I had an MRI and CT. I then started advocating for myself. I was able to get surgery on January 22, 2024 at Mt. Sinai. I had stage 3A endometrial cancer and more than half of the endometrium was impacted as well as the cervix and fallopian tubes. The entire process took too long. I did everything I could to obtain a timely diagnosis, but it was to no avail. The system failed me despite my best		

				efforts and I am a physician. What more could I have done? “		
B. WERE YOU SYMPTOMATIC WHICH LED TO INVESTIGATIONS? TELL ME A BIT ABOUT YOUR JOURNEY?	“Yes, I was symptomatic because I had bleeding which led me to go see the doctor who referred me to a specialist who then did a D&C and then a hysterectomy. “	“That was pretty much it, just the periods that led up to the diagnosis. I had periods more than usual. No menopause which was unusual. My spiny senses were alerting me.”	“Nope, not at all. It was just due to a checkup. That’s how it all started. Little did I know what was about to happen to me and to learn that this was the most popular gyne cancer that was on the rise, well that just floored me!”	“Yes, I was symptomatic which led to the investigations. I had lower back pain and lower abdominal pain, as well brownish vaginal discharge, after having progressed from watery discharge. Urinary frequency was also a symptom.”	“In the recurrent setting (metastatic), typically patients have lung mets and/or liver mets and are typically asymptomatic but may have changes in blood work. They may have pelvic mets and occasionally may have some form of bowel dysfunction in follow up because we are expecting them to progress because of the nature of the disease and there may also be cases of carcinomatosis accompanied by ascites. “	“The incidence and death rate are rising in endometrial cancer. Vast majority of patients present with bleeding and tend to bleed early in the trajectory of the disease and certain patients do not bleed and some misunderstand the significance of bleeding and others have pain, others present with metastatic disease with pain in abdomen, and chest symptoms and lymph nodes in groin. Pain is indicative of advanced disease. Stage 1 indicates best prognosis with ensuing surgery. If present with advanced disease 20% account for stage 3 or 4, they need adjuvant treatment too,

						which is Carbotaxol. But in these patients, the disease comes back and patients survive only 3 years and there is good evidence from the Ruby trial to therefore add immunotherapy (Dostarlimab) to Carbotaxol for MMRd disease accounting for 30% of patients giving them a chance of cure at 4x. We have evidence also in MMRp patients although the magnitude of difference isn't as robust, but it also makes a substantial difference to give Dostarlimab with chemotherapy for these patients who account for 70%. The risk of opportunity is good. Immunotherapy is not alone. When given with chemo, it releases lots of antigens, so the combination makes

						a huge difference! Surgery is the mainstay. If a patient is stage 3, surgery first, then immunotherapy and chemo should be administered. “
C. HOW WAS YOUR CANCER DETECTED/ DIAGNOSED?	“It was diagnosed through my hysterectomy.”	“Through a D&C. which was on January 31, 2024.”	“Through an ultrasound and then confirmed through a biopsy.”	“The cancer was detected through the D&C. “	“Once again, in the metastatic setting, through imaging, CT and may be arranging through biopsies to confirm.”	“When patients have bleeding, it is important to do a biopsy, the biopsy is done through a tiny suction device and suck out the lining of the uterus to make a diagnosis. And ultrasound is also done through the vagina to give the information on the body of the uterus, and fallopian tubes. A D&C and hysteroscopy are done also. Only 20% need this though. The vast majority need a biopsy without anaesthesia. “
D. WERE YOU DIAGNOSED WITH ADVANCED OR METASTATIC DISEASE? IF SO, WHEN?	“It went into remission for a while and then in December 2023 when I started getting in my left	“I was not at first, after the D&C, it came back as stage I endometrial carcinoma. It came back as advanced in	“Yes, in March 2024.”	“I was diagnosed with advanced disease, specifically stage 3A endometrial cancer. I received the	“Lung and liver mets and hematologic spread which is typical of MMRp spread, we are usual looking at	“70% of patients have their disease confined to the uterus and the rest (30%) are diagnosed with stage 3 and 4.”

	hip so when I went in, they found a growth on the very bottom of my spine and that was causing the pain in my hip, hitting a nerve. Eventually, I got to see my doctor, it was cancer. I did a CT scan, and it was not only down there, it was also in my lungs. So, we started chemo and immunotherapy on January 19, 2024, every 3 weeks. And the last chemo and immunotherapy was done on May 3, 2024, so then, on may 24, 2024, I started taking immunotherapy by itself. Then I waited 6 weeks to do immunotherapy by itself again. So, I guess, yes, I was delivered a diagnosis of metastatic endometrial cancer in December 2023. “	the regional lymph nodes: after my D&C, they referred me to the Tom Baker Cancer Centre and they recommended full hysterectomy and that s what they did on April 15, 2024. And it came back saying that there were lymph nodes surrounding the uterus and they grabbed bunches and one in each section came back positive. So then, with that report, they felt I had lynch syndrome because I tested positive for MSI-high and MMR-deficiency. And then, because of that I was very lucky to be a candidate for Dostarlimab and chemo (Carbotaxol) – 6 treatments every 3 weeks. I just finished my fourth treatment.”		official diagnosis in the beginning of February 2024.”	distant spread. and vaginal bleeding is a symptom as well. We will only do MRI if a tumour is pushing on something dangerous and if considering taking them to the operating room.”	

E. HOW DID YOU FEEL WHEN YOU WERE DELIVERED THE DIAGNOSIS OF ENDOMETRIAL CANCER?	"Just totally terrified and I can't remember physically because I haven't had a lot of pain ever, I am so fortunate that way. I didn't think there was any future for me. Quite often people go home to die, my doctor told me, but the doctor told me keep doing what you have been doing, because I have been doing so well. I was on committees, but I got off of them because of my cancer."	"The very first go around, I wasn't worried about it to be honest, cuz everything I read, was that it was curable if caught early. I felt as though I won the lottery. So, I was ok. I didn't really hit me till I got the second diagnosis of stage III. It was truly high anxiety going from stage I to stage III. I felt insecure and fear because at that point I found out I was gonna lose my hair and there was lots to worry about – gripping fear, that's all I can say. And the more I read, the more I learned. I learned this cancer was around a lot in Canada and becoming more and more diagnosed in women. Imagine that. And I had no idea."	"The first one was ok, because it was local. It went pretty quick and I had a hysterectomy, and it was stage 1B, but it was so quick, I felt relatively ok. but the second one was worse, why me? There was nothing to prepare me. How did it get to the thyroid and lungs. It is what it is. I have been fighting lately as much as I can. we shall see."	"First of all it was over the phone. I was on my way to buy a gift for my husband whose birthday it was. I couldn't do away with it because I took a day off from work. It was the end of the world for me. For a long time, I felt as though I failed my family and myself. When I was in more of an objective frame of mind, less emotional, I felt as though the system failed me, not the doctors, but the system that works through guidelines. Each doctor did what they were required to do through the guidelines. And that's why at this point, it is important to advocate on behalf of those who are showing less robust results for the MMRp in comparison to the	"Well usually, they've done a lot of reading, and they often know they have a high risk of recurrence and not curable and have a general idea that is going to cause their death and causes unbelievable stress. They often come out of the other side, and they know what it means to have a recurrence of endometrial cancer. They often approach with hope but there is underlying idea that it is now curable at this point. A lot of fear and a lot of sadness going back to therapy, they have been there and done that and it disrupts their life. The number of times I have had patients cancelling travel and cruises, and shutdown of their lives. There are two groups: the older group who are not well so they are	"Any woman in their proper senses, is devastated to learn of their diagnosis. I much more want to emphasize, if you have cancer that you cannot do anything about, with few effective treatments, when there is level one evidence that can make a difference, this can bring hope and provide a truly significant difference. It's devastating to learn of this diagnosis. But there is evidence to support the use of Dostarlimab. As a civilized society, we treat people with the most effective treatment with much evidence that will make a difference, and it is not worth waiting for this effective, evidence-based therapy."

				MMRd patient population. However, every life matters and my life matters. In the US, immunotherapy is now being recommended in first line in combination with chemo for women such as myself for MMRp advanced and metastatic patients. So this interview is really important to me to help accomplish something meaningful. “	trying to balance their own needs and trying to take care of their own spouses who are themselves not well because they have underlying conditions. And a younger patient group who are taking care of their parents and taking care of their own kids so the stress of both ends is really difficult, the disruption is unbelievable. Women being the primary caretaker is unbelievable when they themselves are diagnosed with a critical illness. It is quite drastic. This is every conversation i have. It is unique taking care of women. I hear: ‘*How am I supposed to do this*’!! “	
8. A. WHAT THERAPIES DID YOU RECEIVE BEFORE DOSTARLIMAB + CHEMO?	“No other therapies. I don’t believe I was. I was on megestrol for a bit. But that’s it.”	“After the D&C, and before the surgery, I was prescribed a strong progesterone:	“Nothing other than surgical therapy, and radiation. “	“After surgery, I received 6 cycles of carbotaxol. I completed them. I did ok on them, nothing terrible. I	“So obviously Carbotaxol, until they no longer respond to the darn thing, doxorubicin which is limited due	“Hormonal therapies for precancerous, and other subtypes of endometrial cancer, Carbotaxol,

		Visanne dienogest. I was on it from Feb 2 to April 15, 2024 – one pill a day.“		started March 5 and I ended July 9, 2024.”	to cardiotoxicity, liposomal doxorubicin (calyx which permits more cycles), and pembrolenva. Sometimes radiation treatment for spot lesions and hormonal treatment ie letrozole.”	immunotherapy (Dostarlimab and pembrolizumab); MMRd patients use Dostarlimab alone or Pembro alone can be given every 6 weeks and the side effect profile is much better for Dostarlimab than for Pembro. The point to be made here is if we use the proper treatment, patients who have roles to play in their lives, such as mothers, sisters, daughters, well if they are not sick then they can continue to make contributions in their lives. I have patients who have been able to continue to make these contributions or play these roles because of immunotherapy such dostarlimab, especially Dostarlimab. They are not in the ER or hospital. They are living good lives. We

						as gyne oncologists also operate so I have a limited number of beds available to me in our ward, so if you have someone who is so sick due to chemo for example, they are occupying a bed that would otherwise not be available to me to a surgical patient so that somebody who needs that bed to have surgery and be cured outright, well, its taking away – it's what we refer to as opportunity costs. Gyne oncs have a different perspective. We want to use our resources well. We want to use the hospital, ER clinics to make the biggest difference in the best way possible for all our patients. "
B. DID THOSE TREATMENTS CONTROL YOUR CANCER? Y OR N PLEASE EXPLAIN.	N/A	"I have no idea if it controlled my cancer. I was prescribed that pill because my surgery	"Well for awhile till we discovered the thyroid and lung mets. So I guess well, it was in the	"I have to say I could not gain weight on that treatment. I lost weight from the	"If you have someone who is carbo sensitive, for a period of time, it will always become	"Initially, it does but once it recurs, after 6 months, then the chemo does not work anymore.

		was so far away. It was a long wait to get into the cancer centre. And it helped to control my anxiety while I was waiting to get into the cancer centre."	blood somewhere hiding, waiting to be discovered."	surgery. With every cycle I continued to get weaker and weaker. My HB went down. I felt I was recovering. Maybe it was mental, but I went from 56kg to 58kg. I lost weight again now. I don't have an explanation as to why. I am eating well now but I don't know. I felt that chemo did me well even though there were side effects."	resistant at some point. Very rarely with hormone sensitive, will they respond; after 5 years few are still around, and same thing with rads. With pembrolenva, I do have patients who have responded well and have come off it after 2 years and those who have completed it after 5 months, it came back, and they are on it again. Some others have responded well and disease free. "	They may be disease free for approximately 6 months. This is why you need the most effective treatment upfront such as Dostarlimab in the advanced setting. If you use it at the right time, it makes a real difference. Adding Dostarlimab to the chemo in the first instance, well, you will secure a better outcome for these patients in terms of disease free survival and survival overall. Giving this immunotherapy in MMRd patients, the tumour must be hot, and these tumours have lots of abnormalities. This is why patients respond so well. In MMRp tumours, they are cold tumours, the immunotherapy must be given with chemo, so that the chemo breaks up the cells and

						tumours have a chance become hot allowing the immunotherapy to work. It's brilliant actually. In the front-line setting, the combination is extremely effective for these patients who are MMRp. There is an unmet need for these patients to fill. And Dostarlimab is filling it."
C. PLEASE DESCRIBE YOUR QoL ON THOSE PREVIOUS TREATMENTS.	N/A	"I had no problems with it at all."	"After the surgery, it was ok, because it was laparoscopic. I was over it pretty quick. After the radiation, I had diarrhea. It was not so bad. I was protecting my skin, I had some redness, but it wasn't as bad as other women. It was ok at the end of the day. I would say minor."	"The side effects of chemo were low mood, which came and went, malaise, poor stamina, and I still have low stamina and I am still not close to what I used to be able to do, with my hands I was very diligent with cryotherapy, and my hands are good now, my toes are a bit sore but my soles of my feet are much better. Other than that, I am good. I have upper back pain, on and off as MSK, it	"So, Carbotaxol, they do tolerate it quite well. They do not get myelosuppression but do get peripheral neuropathy. And in those cases, continue with carbo. Eventually resistance sets in. Patients can go on for 2 years though. Grastofil is indicated in 50% of the metastatic population. And there are those who have an allergy and I have to desensitize them. In the	"If the patients only pursue chemo, they have hair loss, neuropathy, GI issues, but they will put up with this. They put up with a lot because they really haven't had anything else available to them. And it's sad that the disease comes back after a year, 6 months after having ended chemo. Adding Dostarlimab, will not increase side effects but will increase the longevity in both MMRd and MMRp

				doesn't keep me from sleeping."	pembrolenva you'll have blood pressure issues really quick and the fatigue is unbelievable. And bone ache and fatigue and they don't know how bad it is until they stop it. It is quite dramatic. And I haven't had a single person yet who didn't comment to date. A lot of diarrhea on the lenva too. Low grade abdominal pain from the lenva! The Pembro is ok. "	disease. And seeing that the MMRp patients are desperately in need of something that is effective, safe and promotes quality of life, well this is really good for them. Because the unmet need is in the advanced stage disease for MMRp and in the metastatic setting for MMRp endometrial cancer. "
D. HOW LONG DID IT TAKE BEFORE YOU PROGRESSED ON EACH OF THOSE PREVIOUS THERAPIES?	N/A	"There was no progression at all."	"It took approximately a year before I progressed."	"I have no evidence of disease right now."	"Patients typically recur within the first two years and after that they will progress within the first year once they recur and then the time keeps shortening thereafter. "	"It takes 6 months to progress after chemo ends. So within a year to recur."
9. WAS THERE ANY PARTICULAR ASPECT OF THE DISEASE THAT WAS DIFFCIULT TO CONTROL WHILE ON THOSE PREVIOUS	N/A	"No, nothing at all."	"not really."	"No, I don't think so."	"It's more due to the treatments themselves such as the cumulative effects of the treatments such as neuropathy, fatigue, and overall achy	"It's the disease, unlike ovarian cancer, this disease is chemo-resistant. So, when they have advanced disease, and a have bowel obstruction, or

THERAPIES? IF SO, PLEASE EXPLAIN.					pain. They feel as though they have the flue and lasts 5-7 days, resolves but then starts up again with next treatment."	ascites, you want to give it a blow in the front line setting with immunotherapy like dostarlimab. Because once it comes back, it's more resistant and difficult to treat."
PART C: EXPERIENCE WITH THERAPY UNDER REVIEW						
10. LOCATION OF YOUR ADVANCED OR METASTATIC DISEASE.	"Lungs, and in my tailbone."	"It was stage I going into the surgery to my knowledge. But I did have it in my regional lymph nodes all the while which makes me a stage III patient. It was in my uterus and the regional lymph nodes."	"Thyroid and lungs."	"Omentum. Prior to having the surgery. But there are some microscopic disease cells in the omentum which were picked up in the pathology not in the CT. "	"Lung and liver mets and upper paraortic and mediastinal lymph nodes and it's more about the clinical presentation."	"It's typically located in the abdomen and chest."
11. A. WAS YOUR CANCER TESTED FOR ANY GENETIC MUTATIONS? IF SO, AT WHAT POINT IN YOUR CANCER JOURNEY, AND WHAT WERE THOSE MUTATIONS, IF ANY?	"I don't have a hereditary cancer, but my mom's relatives have cancers, but I don't have them. As for anything else, I really don't know."	"I was tested right after my surgery. I tested positive for Lynch Syndrome (MSI-H and MMR-D) and everything else tested negative."	"Yes, it was. After the hysterectomy and again before I started the immunotherapy, I think. I am MSI-H and therefore qualified for the Dostarlimab."	"Yes. Mutations in P53 is mutated, p16, WT, HER2, MMRp, pik3CA, and a few others. "	"Yes, completely, routinely tested for the past 4 years and before that we routinely tested in the research setting out of Vancouver Jessica MacAlpine. Panel is MMR/MSI, CPS, HER2, full panel and of course POLE."	"This type of testing must be done. All women deserve to have their tumours molecularly tested so that they can have access to the best treatment. The are tested for ER/PR, MMR/MSI, CPS, HER2, POLE, etc."
B. HOW DID YOU BECOME AWARE	"They just told me abut it when they	"When they told me it had gone into my	"Well because I am a research scientist,	"I didn't know about it...but I did	N/A	

OF DOSTARLIMAB?	were thinking about giving me treatment. They asked if I would be interested in taking and I replied, sure, whatever. If it will help, I want it. It was the person who told me about the chemo."	lymph nodes, and that chemo would have to start, it would also include an immunotherapy to target my lynch syndrome."	I had been looking for possible therapies for my cancer, so after doing some research, I immediately knew the RUBY trial when my doctor brought it to my attention as a possible therapy for my cancer."	ask about immunotherapy. I was smart enough to read about immunotherapy and I was told that it is given when a patient recurs. As for Dostarlimab. it is given only for MMRd patients. That's what I was told but should be given to MMRp patients too."		
12. HOW DID YOU ACCESS THE THERAPY UNDER REVIEW? CLINICAL TRIAL, PRIVATE INSURANCE, SELF PAY, SPECIAL ACCESS?	"I got it through the cancer centre, that's all I really know…"	"I am still unsure, but I believe it is through special access."	"My oncologist asked for the therapy through Bayshore through special access."	"Unfortunately, I did not access dostarlimab. But if I recur, I may be able to access it, that's what I was told and I intend to do just that."	"MSI high patients in clinical trials. We can get access for metastatic setting. Our MSS patients did not get access unfortunately."	At my centre, patients who were MMRd were able to access the therapy through a patient support program."
13. A. WHEN DID YOU RECEIVE DOSTARLIMAB (DATE)?	"I got it as my first treatment. January 19, 2024.	"I received my first treatment on May 24, 2024, in combination with chemo."	"The first was April 5th, 2024. And in first line therapy."	"I did not receive it unfortunately. But I have every intention of receiving it in the event I recur, and I suspect I will based on the pathology."	"Access for the MSI-High patient started after Christmas 2023."	"This started in the past few months."
B. AND IN WHAT LINE OF THERAPY?	"I think it's first line."	"In first line therapy."	"Through first line therapy."	N/A	"In the recurrent setting for 2nd line therapy. It was in combination with Carbotaxol."	"As Adjuvant therapy."

C. HOW MANY CYCLES DID YOU RECEIVE?	"6 months worth of immunotherapy. I take the immunotherapy every 6 weeks."	"I have had 4 cycles so far."	"I have had 5 cycles out of a possible 6 cycles. After that, the chemo will stop but the immunotherapy will continue every 6 weeks for two years."	N/A		"Our patients received Six cycles in the adjuvant setting and were also receiving it in the metastatic setting where we have patients whose disease has disappeared on them."
14. A. HAVE YOU EXPERIENCED ANY SIDE EFFECTS WHILE ON THIS THERAPY?	"With respect to the immunotherapy, I have felt tired and that's it. I have had no other side effects. It has been really good being on this treatment. "	"I have had no side effects so far. "	"Ummmm…. Good lord, well the usual, the pain in the legs. I have shin pain, in my legs. I have shin pain that predates immunotherapy. So, running down hills has caused this pain and is now worse on the therapy. My GI tract has become upset and I have become limited with some foods. I have GI issues. A small rash on my knees. But the eczema on my head has disappeared because of this treatment."	N/A	"It's all the chemo stuff, hair loss and neuropathy, low blood counts, no different than what patients would experience with just chemo. It terms of Dostarlimab side effects, thyroid disfunction was experienced so we had to prescribe synthroid, they actually have few issues with immunotherapy. We are super good at giving IO, so we jump on things fast!! With the panels we have and monitoring we are really great at giving IOs now. Diarrhea is the only issue in addition to the	"Dostarlimab side effects sometimes it can set off inflammation due to autoimmune reactions, such as skin rashes, pneumonitis, colitis, but the main organ is the skin, as well as the endocrine organ such as thyroid, and arthritis too. And the key is to be alert to work with the patient to treat promptly. Because that can make the difference in the world to getting the reaction under control in a timely manner and improving quality of life so that the patient can stay on

					thyroid dysfunction. So, if you stay on top of those, it has been good. Patients are tolerating the Dostarlimab really well. Patients are finding it quite tolerable. It's always the chemo. I don't find it any different than giving 6 cycles of chemo. In terms of overall monitoring and watching them, it is not more extensive, if that makes sense. We are seeing them every 6 weeks so we are already doing that with the chemo so it is not more burdensome."	the immunotherapy."
B. WHAT WERE THOSE SIDE EFFECTS? PLEASE DESCRIBE THEM.	See above.	N/A	See above.	N/A	See above.	See above.
15. ON A SCALE OF 1-10, HOW WOULD YOU RATE YOUR QOL WHILE ON DOSTARLIMAB? 1 BEING VERY POOR AND 10 BEING VERY	"I would say an **8 or 9** because I can do everything but walk like I used to. I still have a pretty darn good life."	"I am gonna say, **9 or 10**, ya, just knowing that there is something being done, absolutely makes you feel better. "	"Well, I would say a **7 or 8.**	N/A	"In the recurrent setting, they have had chemo before which puts them at a disadvantage in terms of quality of life so in the recurrent setting, they are already starting off in a	"Overall, based on the patients I have treated, I would rate it an **8** most of the time and sometimes a **9, especially** If there is a side effect, we can intersect. The

GOOD. PLEASE EXPLAIN.					compromised physical condition. Once they get going on the therapy, doses can be reduced which can improve their quality of life and then the therapy can reflect a more wholesome quality of life. Once the patient does respond to the therapy, after 3 months you will know if they are, most of the immunotherapy side effects will be well under control and they will have no IO problems later on and when you pull the chemo and left with just IO, you should get them back to pretty much baseline quality of life. So overall, a general metric Quality of life would be **9-10**. But if on chemo, the metric quality of life would be a **6**.	key is to be alert. It is not like chemotherapy. They just go on with their life. If they get arthritis or rash, you must deal with it immediately. And they are usually good to go."
16. DID YOU HAVE ANY	"No, I did not. I had vaginal bleeding	"No, I did not."	Nope.	N/A	"In endometrial cancer, symptoms	"Of course. We have patients who have

ENDOMETRIAL CANCER SYMPTOMS BEFORE STARTING THE THERAPY? IF SO, WHAT WERE THEY?	about 6 or 7 years ago but nothing since."				are not frequent very asymptomatic unless its abdominal symptoms such as loss of appetite, carcinomatosis, for example. But if lung or liver, there usually are no related symptoms. Unless, they have a bronchitis that is not resolving because of a lung met. And there may be a leg edema that is being caused by a lymph node in the abdomen as well that is symptomatic."	been so sick. The tumour obstructed bowel or ureters can cause severe pain. But once we administer the Dostarlimab, the tumours melt away. And they function so well. I have a patient who had a dance school and then reopened it because of Dostarlimab. Another woman had a jewelry shop who is now back at work with her husband because of Dostarlimab. Pain and other symptoms disappear because of this immunotherapy."
17. IF YOU DID HAVE ENDOMETRIAL CANCER SYMTPOMS BEFORE STARTING THE THERAPY, DID THE THERAPY HELP RESOLVE THOSE CANCER SYMPTOMS? IF	N/A	N/A	N/A	N/A	"If it works, yup, I always tell patients, you will know if the treatment is working before I do. I would say that 20-25% of the MSS patient population will respond. None have gained access to	Please see above.

SO, WHICH ONES?					Dostarlimab + chemo though in our clinic and this represents a huge unmet need that needs to be met!"	
18. HOW WAS RESPONSE CONFIRMED TO DOSTARLIMAB? WAS IT CLINICALLY (SYMTPOMS RESOLVED AND YOU FELT BETTER), BIOCHEMICALLY (CA-125 MARKER), OR RADIO-GRAPHICALLY (CT SCAN RESULTS)?	"The blood test, CA-125, that's for sure. And I do have CT scans checking my lungs. The lungs have been shrinking a little bit and one more nodule has stayed the same. The tailbone has been nonexistent in terms of symptoms, I have no pain. I can't say it hurts. I just get tired. My doctor says I am responding to the treatment. My doctor is very pleased with my response to the therapy."	"On May 16th, I had an MRI and CT scan that captured some lung nodules (CT) and lymph nodes (MRI) before starting Dostarlimab with chemo. After 3 cycles of Dostarlimab + Chemo, my oncologist decided to prescribe a PET/CT and it turns out that I have no evidence of disease in my body! Nothing showed up and so I asked, does this mean I have no more cancer in my body? And my oncologist replied 'yes'!! I am so happy. "	"Yes, response has been confirmed through CT. after cycle 3, my thyroid nodule reduced 85%! And the lung nodules reduced by 70%. It's really working for me. I am so happy with the results."	N/A	"In the metastatic setting, we check patients for CA125 if it is a good marker for them, but typically it is not a great marker for endometrial, and CEA, is used, and so is CA19-9; CT which is classic once every 3-4 months, after 3 cycles to evaluate response, but we won't stop IO based on CT scans unless really the results are really obvious; and clinically, how the patient is feeling."	"Response is usually confirmed based on the symptoms patients report so symptomatically and then CT scan will confirm the findings."
19. HAVE YOU EVER HAD TO STOP DOSTARLIMAB? WHY OR WHY NOT?	"No, never."	"Absolutely, not. My body has been strong."	"Yes, we are on pause right now for 3 weeks because my lipase and amylase are through the roof. The lipase is at 850	N/A	"I have not had to stop yet, but I have had to pause because of diarrhea, colitis, and get it under control with steroids."	"Yes, if severe immune reactions are experienced, then we stop the therapy, but we will use steroids. But we have noticed the

			and the amylase is at 350. The levels have to come down and then I can resume therapy. I have a gall stone which is not moving. I am meeting with a GI specialist to see what is going on with my pancreas. And I will have an MRI to determine. One of them is starting to come back down thank goodness. I did do chemo #5 thank God."			therapy continues to work 7 months after stopping the therapy so we are pleased with that and it provides our patients with much comfort. But sometimes we do have to stop permanently if the reaction is quite severe and life threatening. This does not happen often. It is quite rare. But again the beauty is it continues to work. For several months afterwards."
20. HAS DOSTARLIMAB + CHEMO BEEN EASIER TO USE THAN ANY PREVIOUS THERAPIES? WHY OR WHY NOT?	"I think it's been similar. They put the needle in your arm and it's faster of an infusion which is good. The shorter amount of time in the chemo chair is a benefit to me so I can go home earlier now that I am no longer taking the chemo!"	"It is all I have had, so I have been able to tolerate it really well."	"I don't really have anything to compare it to other than surgery and radiation. I have not had any other drug therapies."	N/A	"Not really, not easier, I would be using chemo otherwise. So adding Dostarlimab isn't a big deal. "	"Without a doubt it has been easier to use than other therapies. It's a half hour infusion compared to 8 hours per day of chemo. Dostarlimab is literally a walk in the park compared to everything else. Few patients will experience an autoimmune disorder. But I will say it is generally, well tolerated."

21. HOW HAS YOUR JOURNEY IMPACTED YOUR CAREGIVER /FAMILY?	"It has certainly scared them like it scared me, other than that, it really hasn't affected them a whole lot. They have to take time off of work to take me to appointments and chemo. They are the ones helping me with understanding information. I have a sister who is helping me too. My kids are the ones bearing the burden and their lives have been disrupted in so many ways. I can't begin to tell you."	"Ummm, I think they have been in shock. I have 2 daughters who are expecting babies, but they are worried about me, but it has been so stressful for them. They want to be excited about their upcoming deliveries, but totally worried about me. I don't know how to help them while I am trying to help me."	"Because I am a fighter, some are taking it ok and others are not. My dad Is not so happy with it. Some of my friends are not taking it very well. What can you do."	"I have to say that I had to see my grandchildren leave because I couldn't have any contamination after chemo. My husband went with me to every appt and treatment. And this was at the expense of his work. My young son was overseas and came back for me. Young people travel but it is definitely a financial cost on us because he has yet to establish himself. Definitely the fact that I am off work, as a physician, I am now on disability, I am definitely grateful now, but I don't know when I will go back. We kept everything private, only a couple of my colleagues and close family know our situation. We didn't share it with any one else. No one has a preconceived	"ummmm ….it's funny, who is it that always steps up, it's the woman who takes care of their parents and children. It's a 3-year long treatment, so when I tell them that, their eyes widen. They don't understand the process that it is lifesaving. Dostarlimab is potentially lifesaving so it's 3 years long, it can't be overnight. If we weren't using it, I would be using chemo anyway. They reach a point in time where they aren't coming off treatment. But they need to understand that this might be curative, we don't' know. Their loved one needs to understand what is happening as well and this is a big deal. It's a bit like coming to the spa every 3 weeks and	"I will share with you that If the patient's symptoms are not well tolerated, and the cancer is not controlled this is devastating to the family and they have a difficult time coping. Things like bowel blockages, ascites, symptoms that behave like ovarian cancer in other words, like pleural effusion, ureter obstruction, it can be not only debilitating but difficult to cope with for the patient and the family. It makes the journey almost intolerable, and I see this first hand how they suffer. This is a difficult journey."

				notion of us. We want to live a completely normal life as much as possible. I don't want to be seen as a person who has aggressive, advanced, metastatic endometrial cancer. I think I have a good support system. But I do think about my husband's support system because he doesn't show his emotions. I talk to him many times, and even he hasn't shared it with anyone including at work."	having a treatment, but it's a bit overwhelming for everyone. But eventually, they come to terms with it. Emotionally, it can be draining, no doubt, and not everyone deals with it the same way or very well. But women all deal with it quickly. "	
22. WAS IT WORTH ACCESSING DOSTARLIMAB? WHY OR WHY NOT?	"Ummm, well when I first went, my doc told me if I had no treatments at all, I would live maybe a year. With this, I would live perhaps 3 years. I didn't want to do it but my son got so upset, I decided to do it. So yes, I am happy that I did it. It has bought me time with my kids and	"Oh yes, 1000% it has been. Any time there is an option to help fight a killer disease, anything that can help fight this in your back pocket is extremely important and this has clearly proven to be extremely important and effective for me! It can be for others too!"	"Well, when I saw the results, we were happy to see the increase in survival, so yes, if the problem is resolved and not due to the immunotherapy. The overall survival will definitely increase. As a researcher, I believe in the data so yes, this therapy gives me hope."	N/A	"I haven't had anyone state regret accessing the drug. I have had lots that they are happy they are on IO, it's the latest thing. They feel like they are on the state of the art therapy and therefore providing hope. You have to have hope because it's an absolutely unbelievable	"Oh my god yes, absolutely. There are very many women who are alive today because they accessed Dostarlimab. Without it, they likely would not be here and they are sincerely happy and grateful. They understand what it means to have been

	grand kids. Time is precious and it is a commodity that has no price tag, it can not be defined."				journey to undergo to be poisoned every 3 weeks. You are manipulating your body to induce your immune system to attack itself and if it works its great but if it produces damage, it can be painful, on more than just one level. So you have to have hope along the way."	able to access this immunotherapy."
23. DID ACCESSING DOSTARLIMAB ALLOW YOU TO FULFILL OR ACCOMPLISH ANYTHING THAT YOU WOULD NOT HAVE OTHERWISE BEEN ABLE TO DO HAD YOU NOT ACCESSED THE THERAPY? WHAT HAS IT ALLOWED YOU TO DO IN LIFE? PLEASE EXPLAIN.	"We have been talking about going on trips. And I don't think I would be here today and I can do extra things that I don't think I would be able to do were it not for the immunotherapy. Examples: one grand daughter just graduated from university, and I believe I would have missed that. She was out of town! And another grand daughter is graduating next year, and I believe I will be able to attend she is	"Ya, I wanted 5 years more life, and I think the immunotherapy is a huge component in helping me achieve that and see the birth of my 2 grandchildren with whom I will be able to see and spend time with, enjoy and love and nurture. I am so grateful but more importantly, I think I can now push the envelope with Dostarlimab to ten years. I think I can actually be cured of this disease because of this therapy."	"I don't know because I have never been without. I continue to work as a researcher; I work in the morning and take afternoons off. I do meditation yoga. I exercise and take walks. I live alone so I take care of my home, vacuum, I take care of my pet, I do household chores, and I do everything for myself at home. I have gone to my friends for dinner at their place. This is all about living life while on the therapy. "	N/A	"I have not had anyone on this regimen to have that expressed to me yet, cuz these are not a lot of people yet. I have had others who would not be here without it today. But not for this protocol. And that's due to time. "	"Yes, we have patients, seeing their children graduate, being able to see children marry, spending time with grandchildren, going on safaris, of all things, traveling to Europe, done things that they could not have done or imagined. We tell them to travel within canada because the treatment is every 6 weeks, so we don't want them to go too far. They can go off and do what they want in

	located in BC! I am thinking of going to Manitoba, my hometown, to join my sisters this summer and I wouldn't be able to do that were it not for immunotherapy! I credit Dostarlimab for my ability to travel and spend quality time with my family."					Canada. We look after people from the north, the Innuits for example. We give Dostarlimab and off they go. They were able to get this infusion to go off for 6 weeks and do wonderfully meaningful things with their lives. And they are still here today."
24. WHAT IMPROVEMENTS WOULD YOU LIKE TO SEE IN A DRUG THERAPY THAT ARE NOT CURRENTLY AVAILABLE IN OTHER THERAPIES?	"Well of course I want a cure, that should be number one! And if we could take that drug via pill, as opposed to going to the cancer centre, cuz it's so time consuming, that would be great. As for side effects, I am pretty good. I can't complain. I have never thrown up or been nauseated. So, for me, those are the big ones."	"In this instance, make it affordable and available to everyone, not just a few. Help cure cancer. When you get a diagnosis, make it affordable and available to everyone who needs it and bring their cancer into remission. "	"I think the survival rate should be higher. If chance of survival is higher, because don't we all want that? And the side effects should be eliminated. It should increase our chance of survival without bad side effects. If you are bed ridden and chance of survival is increased by just a month, it's not worth it."	"I would like to see a drug therapy to be implemented as soon as evidence comes along or at the discretion of clinicians regardless of the guidelines existing to have an individual approach for rare and advanced diseases. I would like it to cure the disease because the rest is in between. Doesn't everybody want that? "	"Oral agents would always be great because chair time and hours spent in chairs is difficult!! Dostarlimab is 3 years of treatment, and we are willing to give it but that is 3 years of patients' time and that is a massive burden on our healthcare system so if we can relieve it, that would be great. Seeing that we are giving effective treatments, we need to relieve healthcare burden, we need to give oral treatments. There	

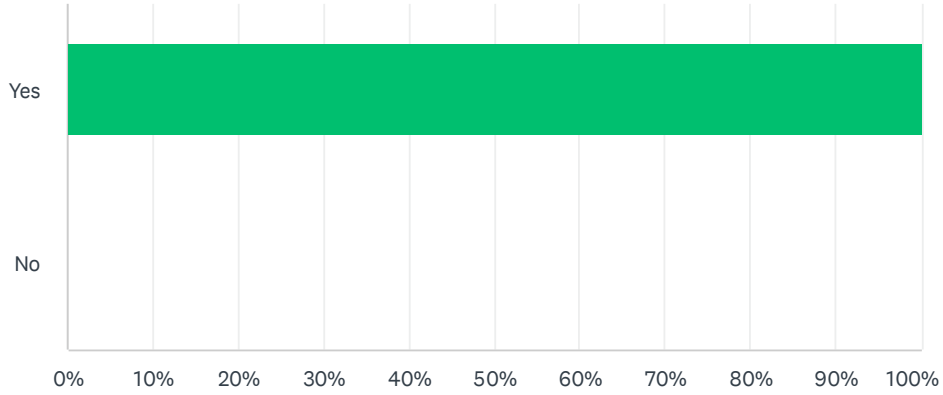
					would be less requirement for bloodwork, less requirement for pharma, this is huge.“	
25. DO YOU BELIEVE DOSTARLIMAB HAS THOSE DESIRED IMPROVEMENTS? WHY OR WHY NOT?	“Yes, it definitely has no side effects which is terrific. And who knows, maybe it will keep me alive for a long time.”	“I would say yes now. It’s so hard to tell because I am doing it in conjunction with chemo, but I have the extra fight or punch with Dostarlimab, and I believe it is achieving greatness for me because it is targeting my specific cancer.”	“I think so yes. The trial is showing 40% increase in survival. I am so grateful. I just need my pancreas to cooperate. And I feel ok otherwise. One step at a time!”	“Let’s say yes, even though I haven’t had it but I believe the literature. It was interchangeable in my discussion, that’s why I say yes!”	“I will say if it can keep a patient from going on a further line of therapy because the toxicities are less, and the patient is utilizing fewer resources and being given the protocol every 6 weeks and the chair time is 30 minutes, then I would say yes! This is a much easier drug than others such as chemo.”	
26. DO YOU WISH TO ADD ANYTHING ABOUT WHY ACCESSING DOSTARLIMAB + CHEMO IS SO IMPORTANT TO ADVANCED OR METASTATIC ENDOMETRIAL CANCER PATIENTS AND CAREGIVERS?	“Well, for one thing, the chemo is ok but the immuno is a whole lot easier because of so few side effects. And of course it keeps you alive a lot longer. In Canada, we really brag about having free healthcare, I think it’s ridiculous if we should be expected to pay for it and in need of it.	“I am very happy improvements are being made and that women’s cancers are finally being acknowledged so that we have a fighting chance at being cancer free through therapies such as Dostarlimab.”	“Well, you know, we don’t want to die in 2 months. The chance of extending survival is important while enjoying life. So, let’s get this approved for everyone, not just MSI-H women. We all deserve it. Every woman deserves a fighting chance at life when diagnosed with endometrial	“It’s important to me as the patient, my family and all stakeholders across Canada because it will save or prolong lives. It should be made available to patients like me in first line treatment because it has been shown to be effective in preventing disease progression in the	“I maintain there is a huge unmet need for the MMRp and MSS endometrial cancer patient population. These patients do not have good, effective treatments once platinum resistance sets in. End of story. And significant loss of quantity and quality of life especially in women	

	Let's get this to the women who truly need it like me."		cancer. And maybe decreasing the quantity of chemo would be nice but getting the immunotherapy to women is imperative. This therapy works. So, let's approve and fund it for all. We need to ensure it is available for all, not just through special access."	studies in people with advanced or metastatic MMRp endometrial cancer. And it has shown to increase survival. MMRp patients deserve it. We make up the majority of endometrial cancer patients who have been looking for solutions, more options, hope and we finally have it. I needed this option but wasn't offered it. So now, in the event I recur, I will make sure I get it, even if I have to pay for it. This is true innovation and as a physician, I recognize that metastatic endometrial patients should be afforded this innovation. Please fund this therapy for the majority of endometrial cancer patients who have been desperately waiting for another effective treatment option that has	in their 50s and 60s who are primary caregivers to their children and parents and are contributing members of society and are still gainfully employed should be a primary concern. Making up about 70% of endometrial cancer patient population is the MMRp/MSS molecular subtypes and discussions should be left to the clinician and patient, with respect to the tolerance, toxicities, and efficacy of Dostarlimab because these issues are discussed during the patient/oncologist consultation. Without Dostarlimab, patients will rapidly deteriorate with chemo or to their less effective agents, leaving a hole in their family	

				been sorely lacking for decades. “	life. These women will die with an IV in their arms - we will not save any healthcare resources by not treating them: on the contrary, we will incur more healthcare resources by having them go to the ER, increase hospitalizations, treatment induced toxicities, and as a result, suffer the burden of caring for them in our clinics and centres across Canada due to ineffective and toxic treatments. The decision to access Dostarlimab + chemo for which there is evidence to support its utility should be left to the clinician and their patient. Please issue a positive funding recommendation. “	

Q1 Are you a resident of Canada?

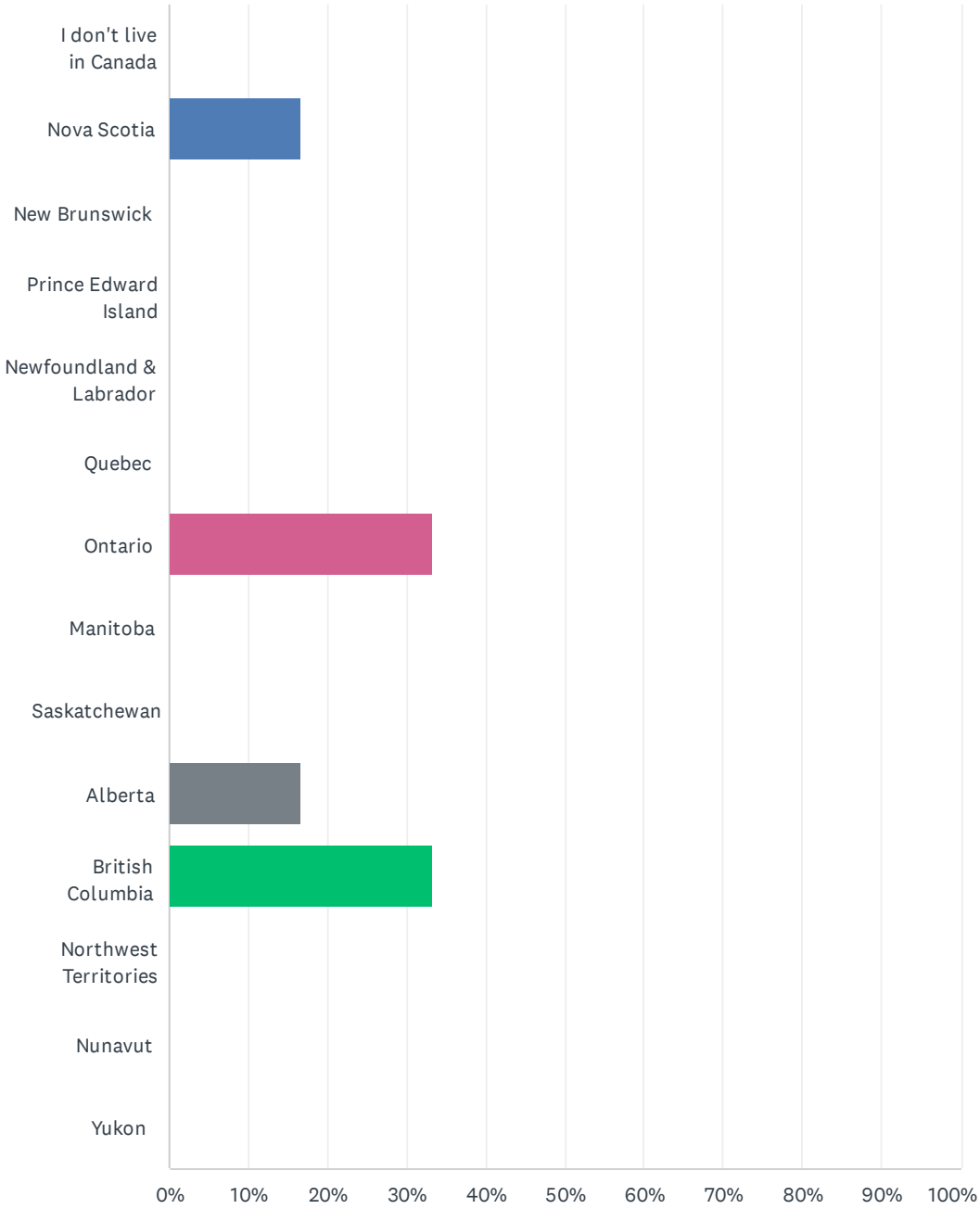
Answered: 6 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	100.00%	6
No	0.00%	0
TOTAL		6

Q2 If you are a resident of Canada, in which province or territory do you reside?

Answered: 6 Skipped: 0



ANSWER CHOICES	RESPONSES	
I don't live in Canada	0.00%	0
Nova Scotia	16.67%	1
New Brunswick	0.00%	0
Prince Edward Island	0.00%	0
Newfoundland & Labrador	0.00%	0
Quebec	0.00%	0
Ontario	33.33%	2
Manitoba	0.00%	0
Saskatchewan	0.00%	0
Alberta	16.67%	1
British Columbia	33.33%	2
Northwest Territories	0.00%	0
Nunavut	0.00%	0
Yukon	0.00%	0
TOTAL		6

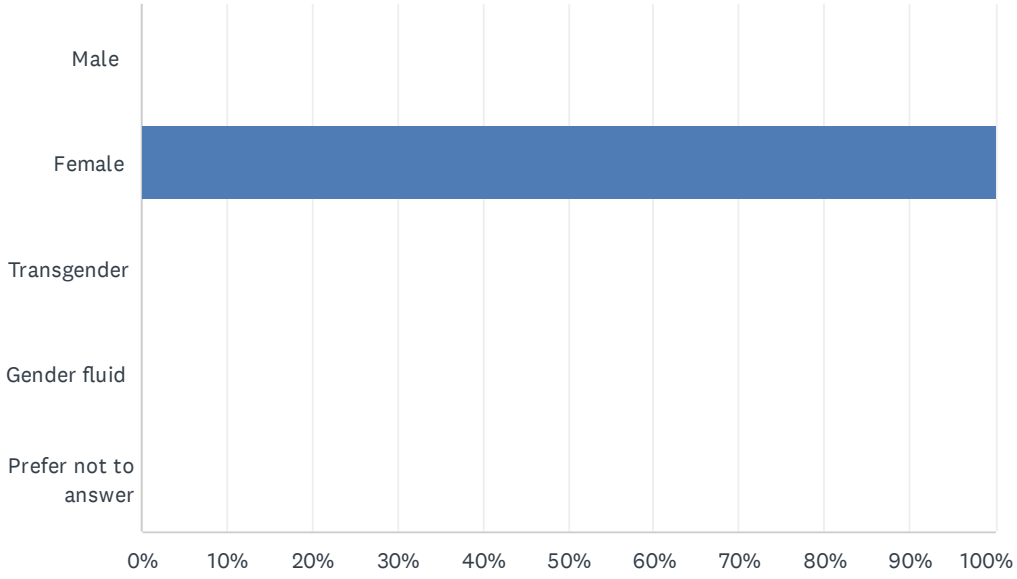
Q3 If not a resident of Canada, in which country do you live?

Answered: 0 Skipped: 6

#	RESPONSES	DATE
	There are no responses.	

Q4 What gender do you identify as?

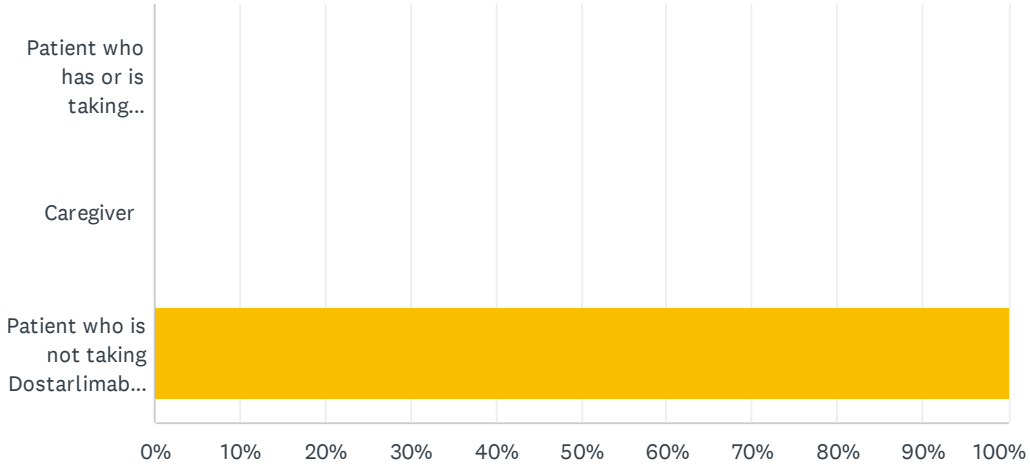
Answered: 6 Skipped: 0



ANSWER CHOICES	RESPONSES	
Male	0.00%	0
Female	100.00%	6
Transgender	0.00%	0
Gender fluid	0.00%	0
Prefer not to answer	0.00%	0
TOTAL		6

Q5 Are you a patient or a caregiver?

Answered: 6 Skipped: 0

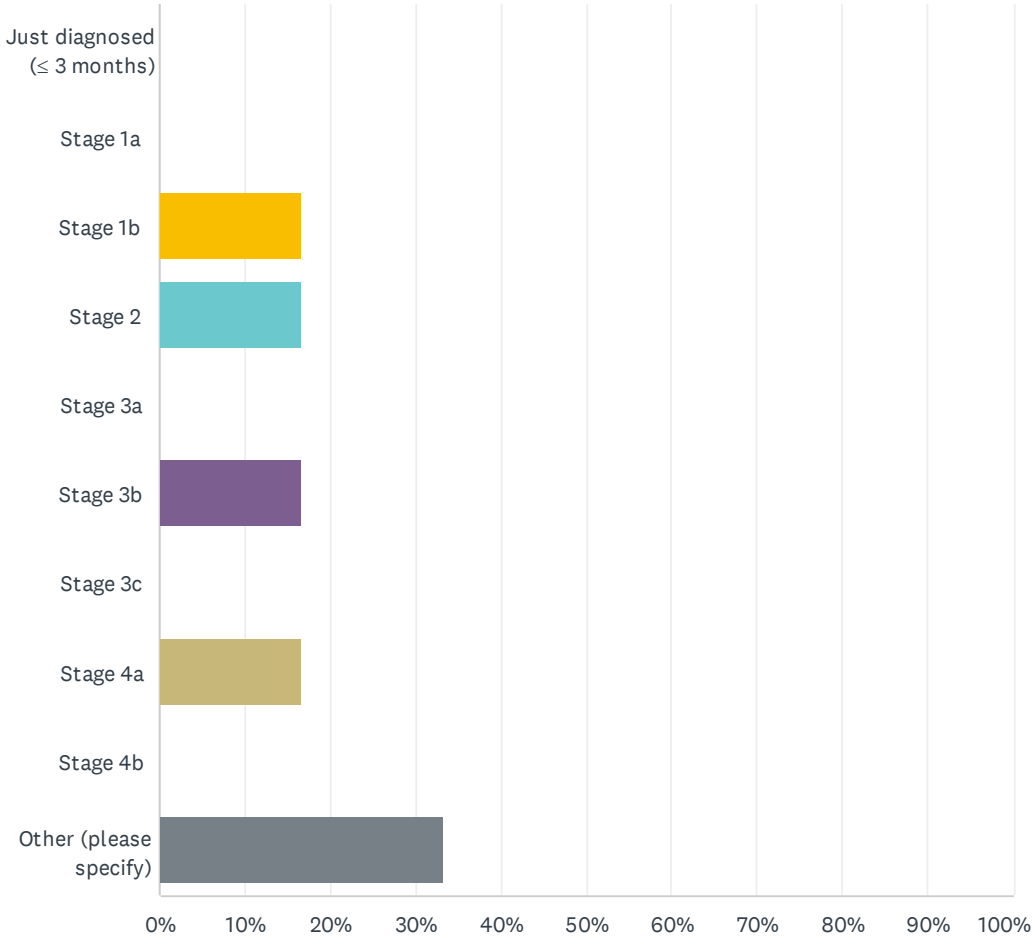


ANSWER CHOICES	RESPONSES	
Patient who has or is taking Dostarlimab	0.00%	0
Caregiver	0.00%	0
Patient who is not taking Dostarlimab (please specify treatment)	100.00%	6
TOTAL		6

#	PATIENT WHO IS NOT TAKING DOSTARLIMAB (PLEASE SPECIFY TREATMENT)	DATE
1	I am NED and on no drugs	10/31/2023 7:15 PM
2	niraparib	10/29/2023 3:29 PM
3	Exmethestane	10/29/2023 1:28 PM
4	none in remission	10/28/2023 2:53 PM
5	Had taxol/carboplatin	10/28/2023 11:57 AM
6	Hysterectomy and brachytherapy	10/28/2023 11:55 AM

Q6 What is the stage of your endometrial cancer?

Answered: 6 Skipped: 0

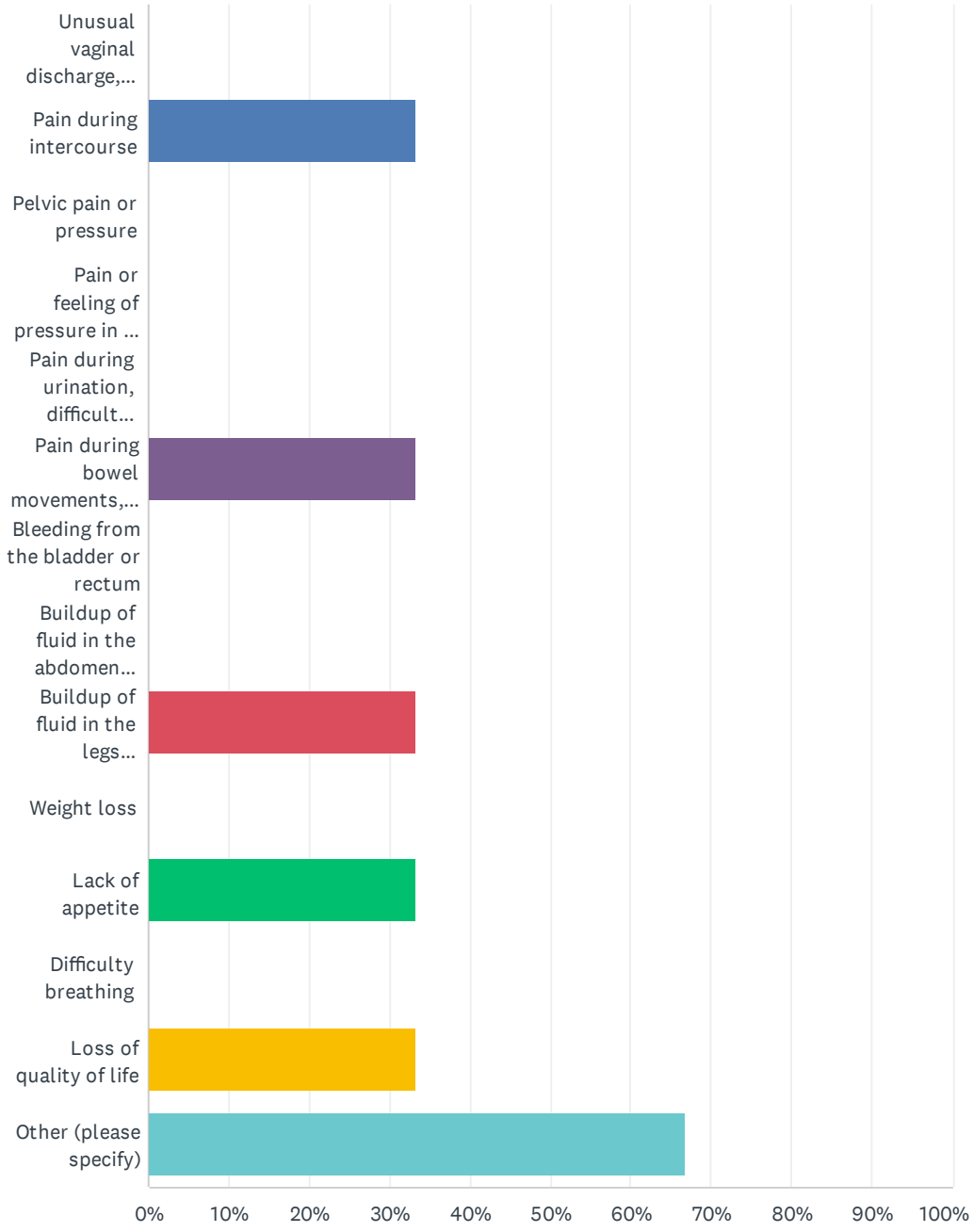


ANSWER CHOICES	RESPONSES	
Just diagnosed (≤ 3 months)	0.00%	0
Stage 1a	0.00%	0
Stage 1b	16.67%	1
Stage 2	16.67%	1
Stage 3a	0.00%	0
Stage 3b	16.67%	1
Stage 3c	0.00%	0
Stage 4a	16.67%	1
Stage 4b	0.00%	0
Other (please specify)	33.33%	2
TOTAL		6

#	OTHER (PLEASE SPECIFY)	DATE
1	mine was breast cancer	10/29/2023 1:28 PM
2	Do not have this type of cancer	10/28/2023 2:53 PM

Q7 What are the symptoms or problems you experience with endometrial cancer that affect your quality of life (such as your day-to-day living)? Please check all that apply.

Answered: 3 Skipped: 3

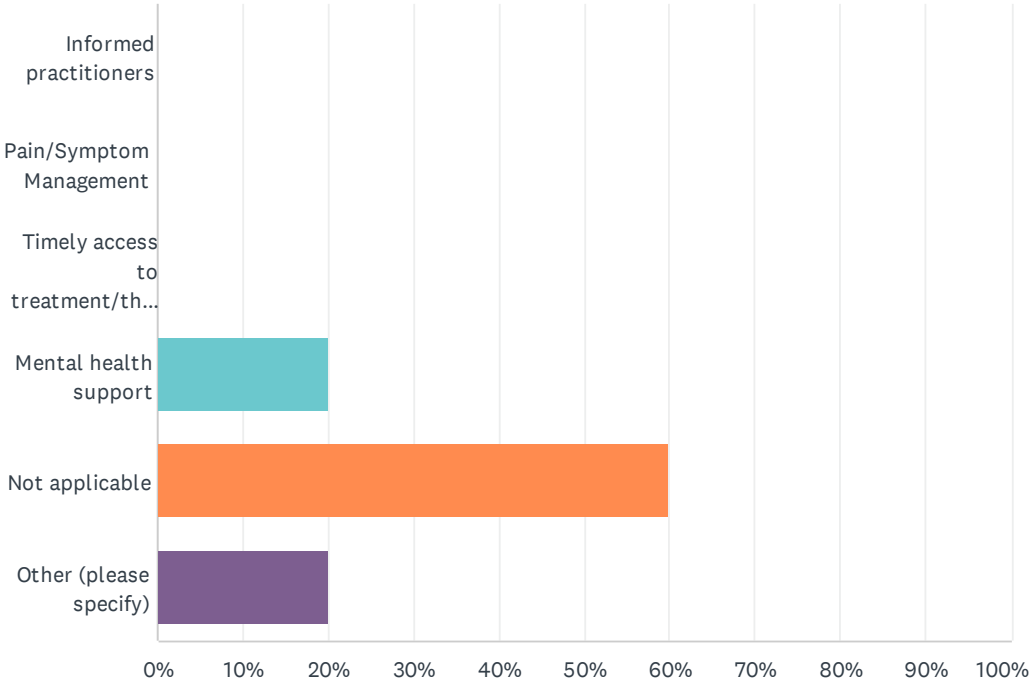


ANSWER CHOICES	RESPONSES	
Unusual vaginal discharge, which can be foul smelling, pus-like, or blood-tinged	0.00%	0
Pain during intercourse	33.33%	1
Pelvic pain or pressure	0.00%	0
Pain or feeling of pressure in the lower abdomen, back, or legs	0.00%	0
Pain during urination, difficult urination, or blood in the urine	0.00%	0
Pain during bowel movements, difficult bowel movements, or blood in the stool	33.33%	1
Bleeding from the bladder or rectum	0.00%	0
Buildup of fluid in the abdomen (Ascites)	0.00%	0
Buildup of fluid in the legs (Lymphedema)	33.33%	1
Weight loss	0.00%	0
Lack of appetite	33.33%	1
Difficulty breathing	0.00%	0
Loss of quality of life	33.33%	1
Other (please specify)	66.67%	2
Total Respondents: 3		

#	OTHER (PLEASE SPECIFY)	DATE
1	n/a	10/29/2023 1:28 PM
2	Tired when I get up, lack of stamina	10/28/2023 11:57 AM

Q8 Are there any needs in your current therapy that are not yet being met?

Answered: 5 Skipped: 1

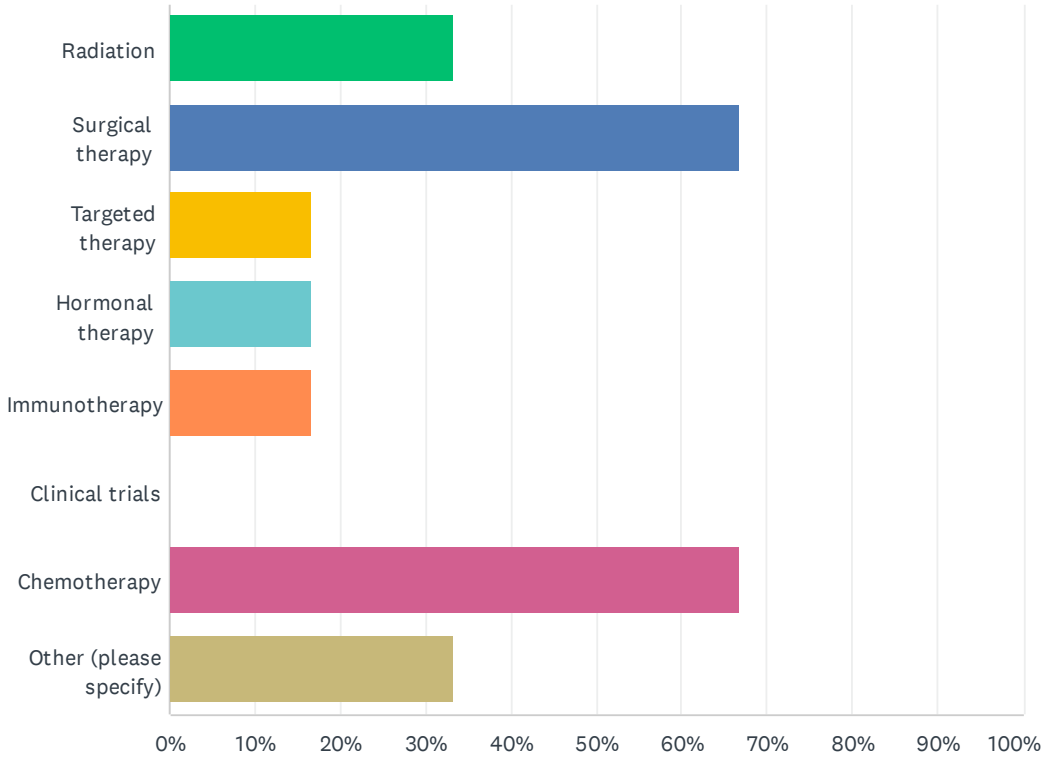


ANSWER CHOICES	RESPONSES	
Informed practitioners	0.00%	0
Pain/Symptom Management	0.00%	0
Timely access to treatment/therapy	0.00%	0
Mental health support	20.00%	1
Not applicable	60.00%	3
Other (please specify)	20.00%	1
Total Respondents: 5		

#	OTHER (PLEASE SPECIFY)	DATE
1	Finished checkups but tgere was never enough time alloted for checkups	10/28/2023 11:57 AM

Q9 What drug therapies or other types of treatments are you currently using, or did you use, to treat your disease? Please check all that apply.

Answered: 6 Skipped: 0



ANSWER CHOICES	RESPONSES	
Radiation	33.33%	2
Surgical therapy	66.67%	4
Targeted therapy	16.67%	1
Hormonal therapy	16.67%	1
Immunotherapy	16.67%	1
Clinical trials	0.00%	0
Chemotherapy	66.67%	4
Other (please specify)	33.33%	2
Total Respondents: 6		

#	OTHER (PLEASE SPECIFY)	DATE
1	I took a pill (don't know the name of it) for 5 years.	10/28/2023 2:53 PM
2	Accupuncture, massage therapy	10/28/2023 11:57 AM

Q10 Is there an aspect of your disease that, to you, is more important to control than others? Please explain.

Answered: 4 Skipped: 2

#	RESPONSES	DATE
1	Recurrence prevention	10/29/2023 3:29 PM
2	no	10/29/2023 1:28 PM
3	I had Brest Cancer that went into the Lymph glans/nodes under my arm	10/28/2023 2:53 PM
4	Kicked out of cancer centre after treament finished. Should have been assigned a nurse for communication. Had to do all my iwn research to get better. Needed better after care.	10/28/2023 11:57 AM

Q11 What adverse effects, if any, were caused by taking Dostarlimab? Please check all that apply.

Answered: 0 Skipped: 6

⚠ No matching responses.

ANSWER CHOICES	RESPONSES	
Anemia	0.00%	0
Fatigue	0.00%	0
Nausea	0.00%	0
Rash	0.00%	0
Diarrhea	0.00%	0
Vomiting	0.00%	0
Other (please specify)	0.00%	0
Total Respondents: 0		

#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Q12 Were these adverse effects of being treated with Dostarlimab tolerated (i.e. symptoms were managed with other treatment/medications and you did not have to discontinue use of Dostarlimab)? If yes, how did you manage them?

Answered: 0 Skipped: 6

⚠ No matching responses.

ANSWER CHOICES	RESPONSES	
No	0.00%	0
Yes	0.00%	0
TOTAL		0

#	YES	DATE
	There are no responses.	

Q13 How were you able to gain access to Dostarlimab? i.e. clinical trial, private insurance

Answered: 0 Skipped: 6

#	RESPONSES	DATE
	There are no responses.	

Q14 In your own words, please describe the advantages and disadvantages of Dostarlimab and how they made an impact on your life.

Answered: 0 Skipped: 6

#	RESPONSES	DATE
	There are no responses.	

Q15 Would you recommend that Dostarlimab be made available to all patients who qualify for it? 1 being 'Absolutely Not' and 5 being "Yes, immediately'.

Answered: 0 Skipped: 6

⚠ No matching responses.

	1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0	0.00

Q16 In comparison to other therapies, how was your treatment experience with Dostarlimab in treating your endometrial cancer?

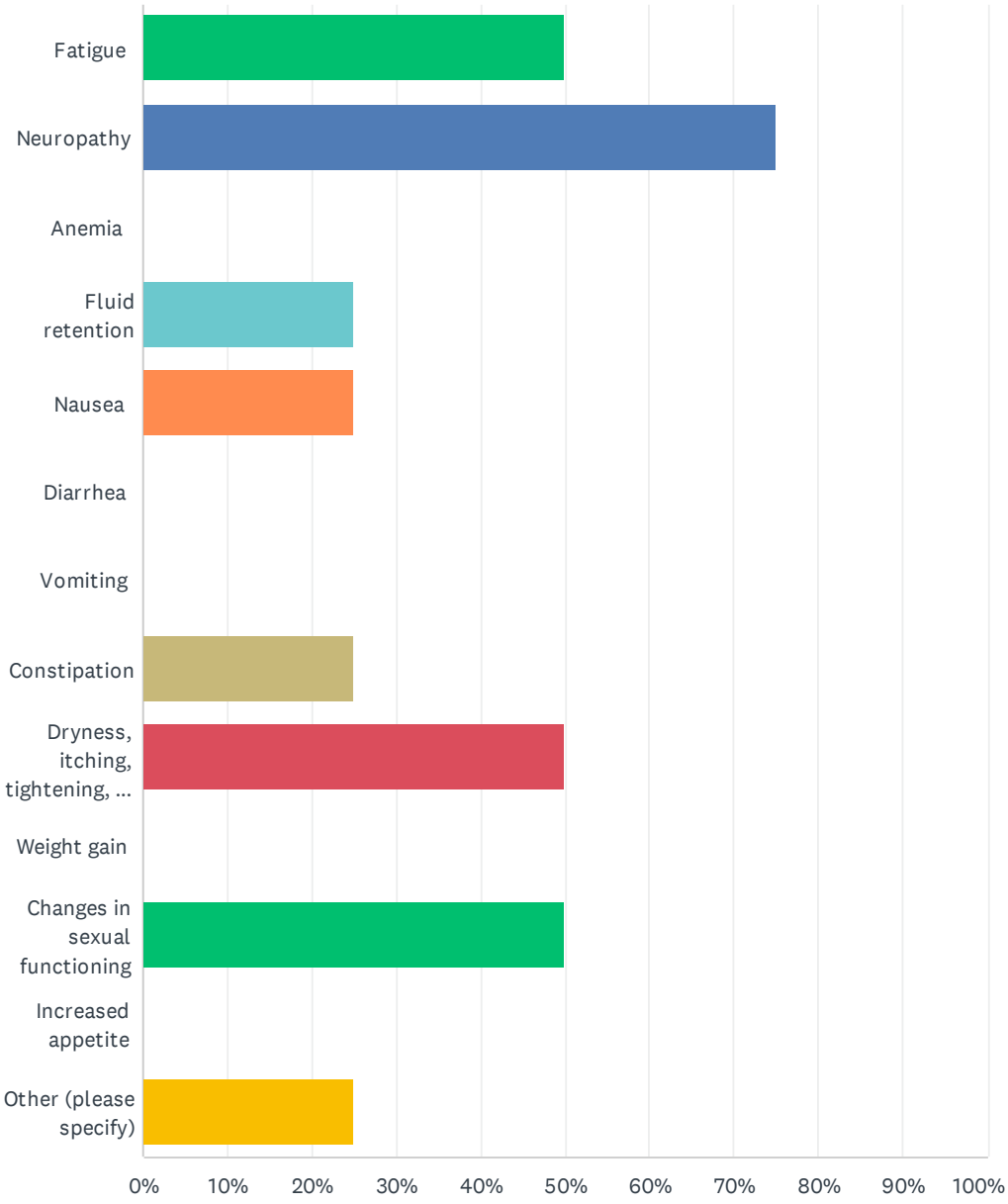
Answered: 0 Skipped: 6

⚠ No matching responses.

	MUCH BETTER	LITTLE OR NO DIFFERENCE	MUCH WORSE	TOTAL	WEIGHTED AVERAGE
Symptom management	0.00% 0	0.00% 0	0.00% 0	0	0.00
Side effects	0.00% 0	0.00% 0	0.00% 0	0	0.00
Ease of use	0.00% 0	0.00% 0	0.00% 0	0	0.00
Disease progression	0.00% 0	0.00% 0	0.00% 0	0	0.00

Q17 What adverse effects, if any, were caused by your current treatments? Please check all that apply.

Answered: 4 Skipped: 2

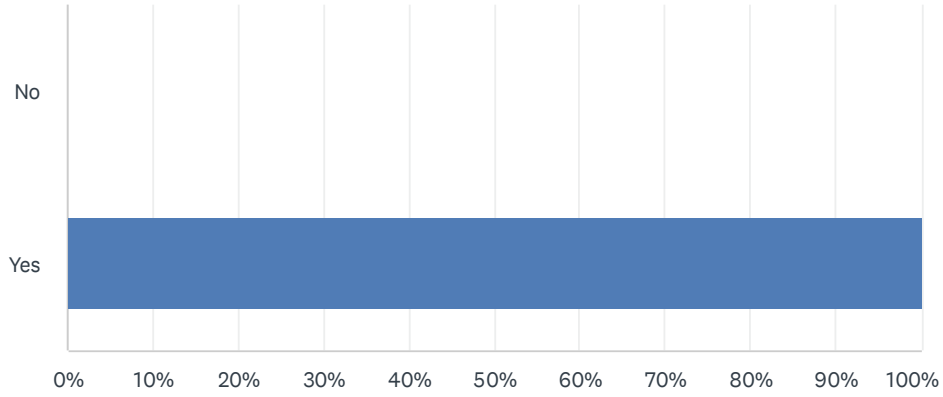


ANSWER CHOICES	RESPONSES	
Fatigue	50.00%	2
Neuropathy	75.00%	3
Anemia	0.00%	0
Fluid retention	25.00%	1
Nausea	25.00%	1
Diarrhea	0.00%	0
Vomiting	0.00%	0
Constipation	25.00%	1
Dryness, itching, tightening, and burning in the vagina	50.00%	2
Weight gain	0.00%	0
Changes in sexual functioning	50.00%	2
Increased appetite	0.00%	0
Other (please specify)	25.00%	1
Total Respondents: 4		

#	OTHER (PLEASE SPECIFY)	DATE
1	Chemo brain	10/28/2023 11:57 AM

Q18 Were the adverse effects of your current treatment tolerated (i.e. symptoms were managed with other treatment/medications and you did not have to discontinue use of Dostarlimab)? If yes, how did you manage them?

Answered: 2 Skipped: 4

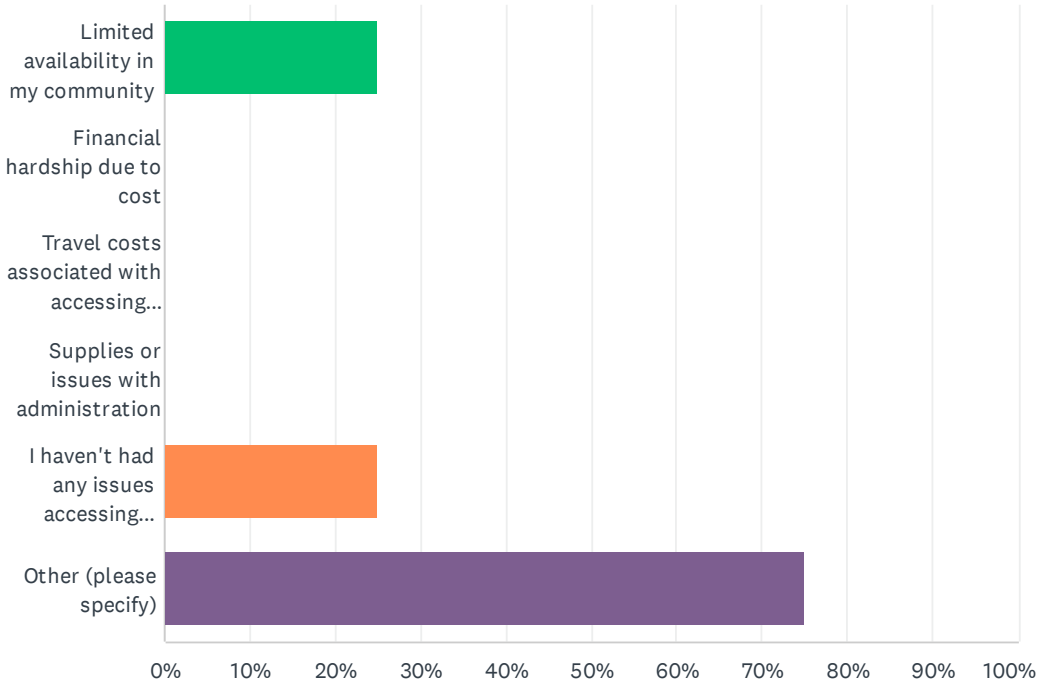


ANSWER CHOICES	RESPONSES	
No	0.00%	0
Yes	100.00%	2
TOTAL		2

#	YES	DATE
1	half dosage; nausea occasionally; proclorperazine	10/29/2023 3:29 PM
2	N/a	10/28/2023 11:57 AM

Q19 Have you had issues accessing any therapies? If so, what issues have you experienced? Please check all that apply.

Answered: 4 Skipped: 2



ANSWER CHOICES	RESPONSES	
Limited availability in my community	25.00%	1
Financial hardship due to cost	0.00%	0
Travel costs associated with accessing therapy/treatment	0.00%	0
Supplies or issues with administration	0.00%	0
I haven't had any issues accessing therapy	25.00%	1
Other (please specify)	75.00%	3
Total Respondents: 4		

#	OTHER (PLEASE SPECIFY)	DATE
1	Any clinical trial using Dostarlimab with niraparib was never mentioned by the clinician	10/29/2023 3:29 PM
2	Had difficulty getting a biopsy at my licsl hospital -cancelled twice	10/28/2023 11:57 AM
3	Driving from home to Clinic in winter weather	10/28/2023 11:55 AM

Q20 If a friend asked you how you are managing at this stage in your treatment, what would you tell them? Please fill out the fields for the treatments you have/are receiving.

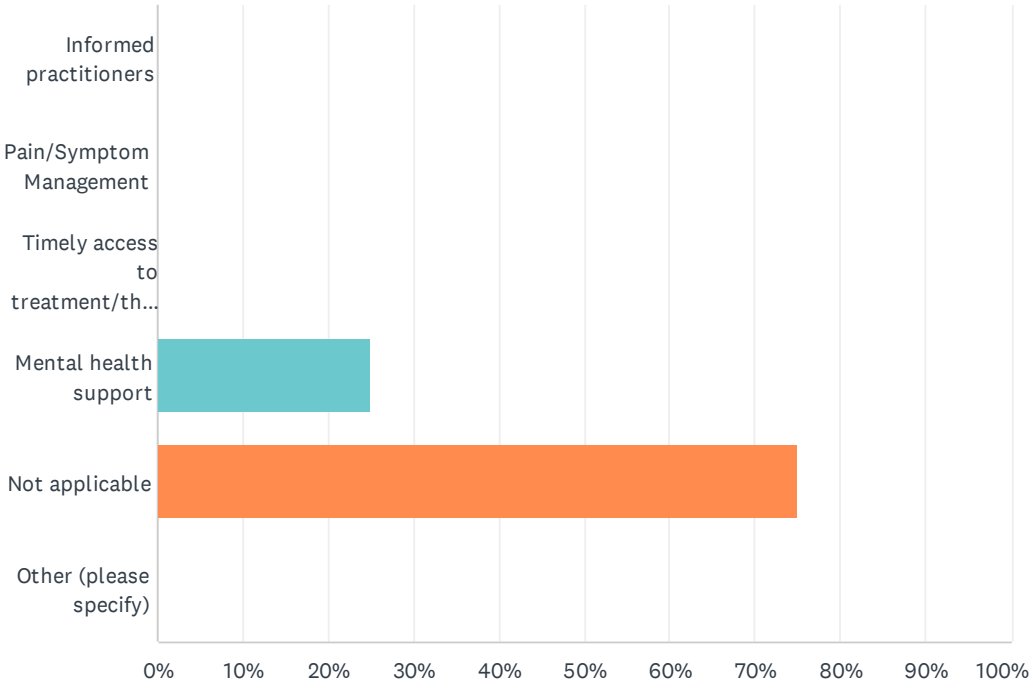
Answered: 3 Skipped: 3

ANSWER CHOICES	RESPONSES	
How are you managing with surgery?	100.00%	3
How are you managing with radiation (internal radiation, brachytherapy, or external beam radiation)?	33.33%	1
How are you managing with hormone therapy (progestins, tamoxifen, LHRH agonists, aromatase inhibitors)?	33.33%	1
How are you managing with chemotherapy (paclitaxel, carboplatin, doxorubicin, cisplatin, docetaxel)?	66.67%	2
How are you managing with immunotherapy (pembrolizumab)?	0.00%	0
How are you managing with targeted therapy (lenvatinib, bevacizumab, mTOR inhibitors)?	0.00%	0

#	HOW ARE YOU MANAGING WITH SURGERY?	DATE
1	Managed well	10/29/2023 3:29 PM
2	ok	10/29/2023 1:28 PM
3	Some bowel oain	10/28/2023 11:57 AM
#	**HOW ARE YOU MANAGING WITH RADIATION (INTERNAL RADIATION, BRACHYTHERAPY, OR EXTERNAL BEAM RADIATION)?**	**DATE**
1	ok	10/29/2023 1:28 PM
#	**HOW ARE YOU MANAGING WITH HORMONE THERAPY (PROGESTINS, TAMOXIFEN, LHRH AGONISTS, AROMATASE INHIBITORS)?**	**DATE**
1	0k	10/29/2023 1:28 PM
#	**HOW ARE YOU MANAGING WITH CHEMOTHERAPY (PACLITAXEL, CARBOPLATIN, DOXORUBICIN, CISPLATIN, DOCETAXEL)?**	**DATE**
1	Was tough; much nausea and contipation	10/29/2023 3:29 PM
2	Affects my thinking, loss of stamina, fatigue	10/28/2023 11:57 AM
#	**HOW ARE YOU MANAGING WITH IMMUNOTHERAPY (PEMBROLIZUMAB)?**	**DATE**
	There are no responses.	
#	**HOW ARE YOU MANAGING WITH TARGETED THERAPY (LENVATINIB, BEVACIZUMAB, MTOR INHIBITORS)?**	**DATE**
	There are no responses.	

Q21 Are there any needs in your current treatment that are not yet being met?

Answered: 4 Skipped: 2

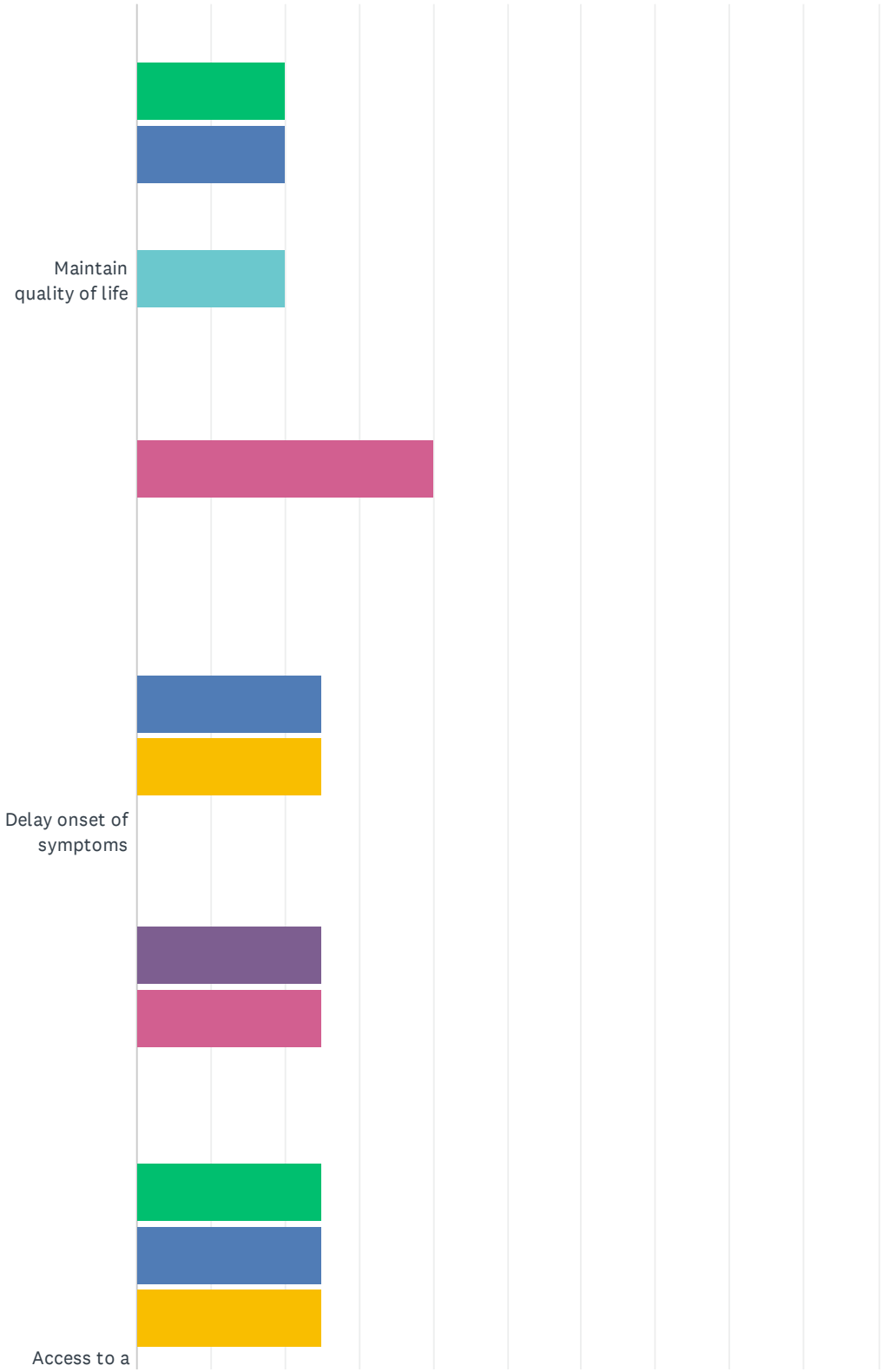


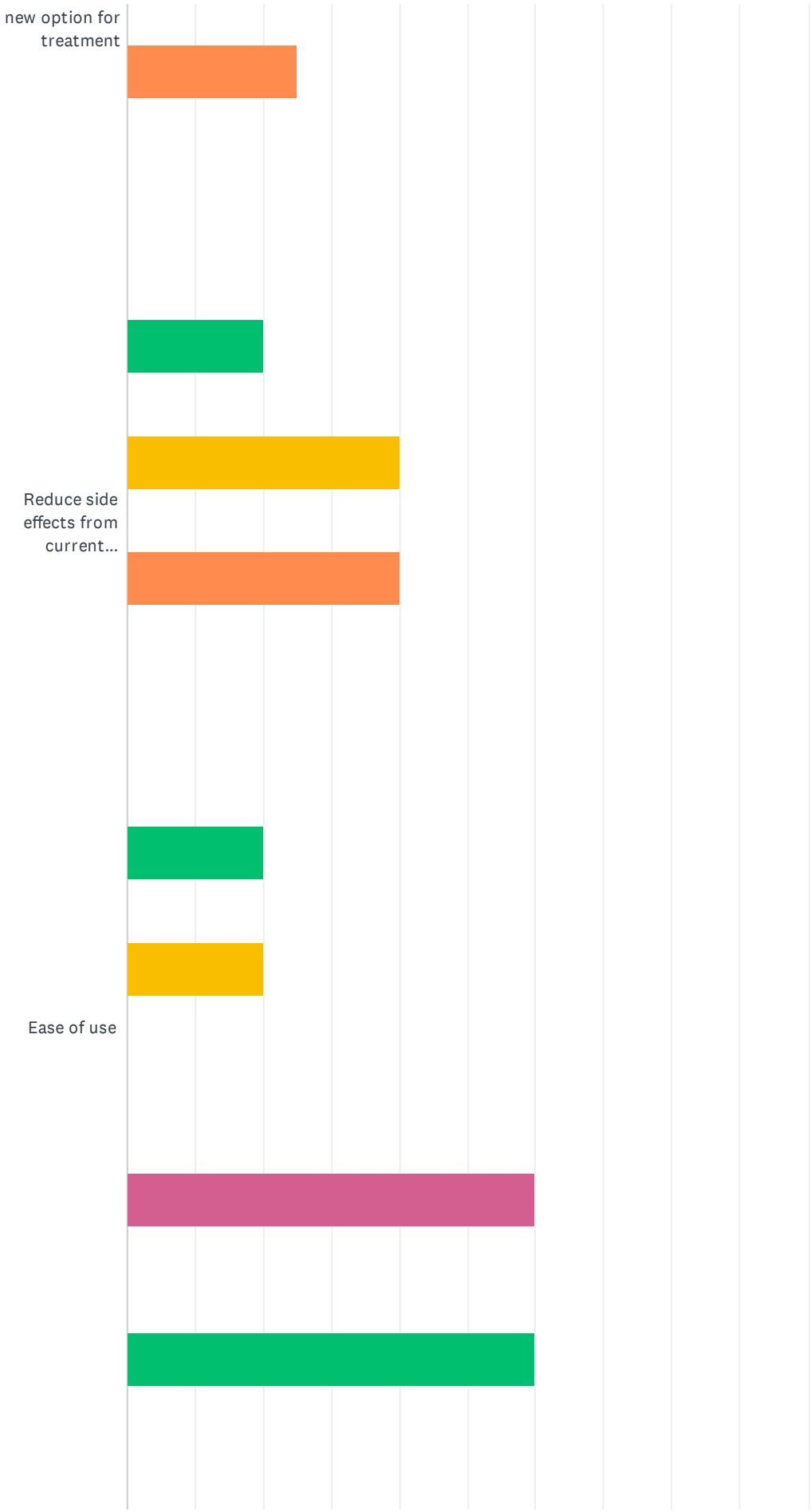
ANSWER CHOICES	RESPONSES	
Informed practitioners	0.00%	0
Pain/Symptom Management	0.00%	0
Timely access to treatment/therapy	0.00%	0
Mental health support	25.00%	1
Not applicable	75.00%	3
Other (please specify)	0.00%	0
Total Respondents: 4		

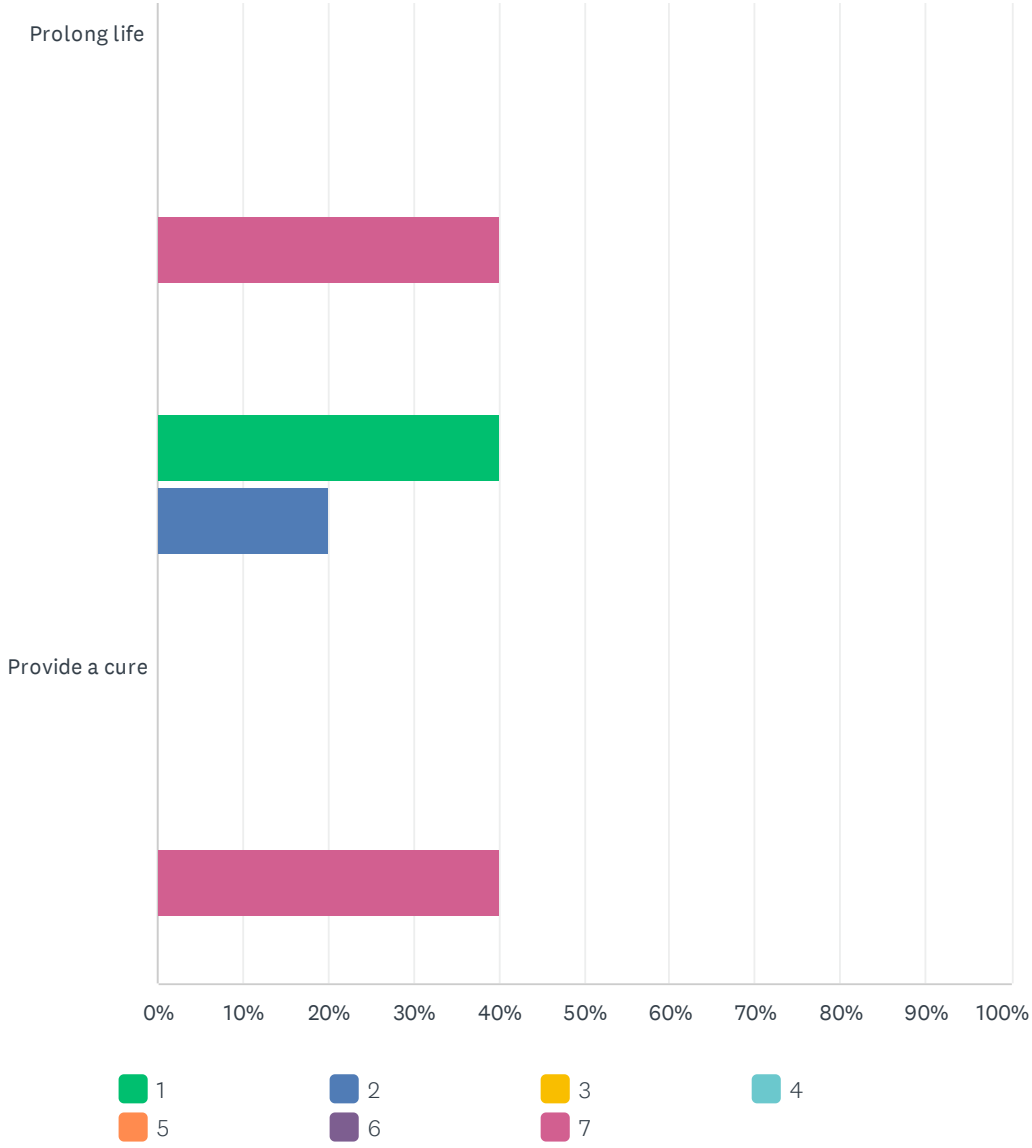
#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Q22 Which of the following issues would you hope that a new treatment would address to manage your disease? Please rate the options from most important (1) to least important (7).

Answered: 5 Skipped: 1



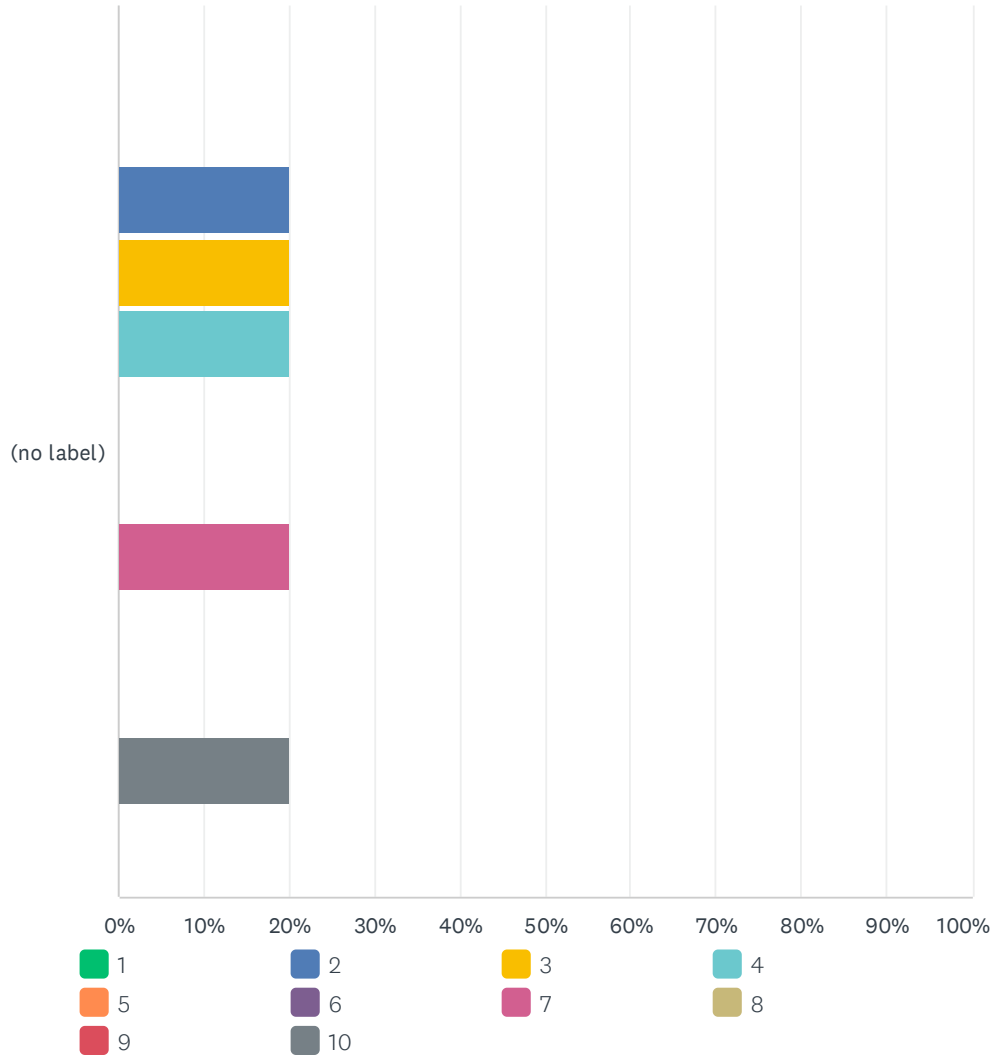

new option for treatment
Reduce side effects from current...
Ease of use



	1	2	3	4	5	6	7	TOTAL	WEIGHTED AVERAGE
Maintain quality of life	20.00% 1	20.00% 1	0.00% 0	20.00% 1	0.00% 0	0.00% 0	40.00% 2	5	4.20
Delay onset of symptoms	0.00% 0	25.00% 1	25.00% 1	0.00% 0	0.00% 0	25.00% 1	25.00% 1	4	4.50
Access to a new option for treatment	25.00% 1	25.00% 1	25.00% 1	0.00% 0	25.00% 1	0.00% 0	0.00% 0	4	2.75
Reduce side effects from current medications or treatments	20.00% 1	0.00% 0	40.00% 2	0.00% 0	40.00% 2	0.00% 0	0.00% 0	5	3.40
Ease of use	20.00% 1	0.00% 0	20.00% 1	0.00% 0	0.00% 0	0.00% 0	60.00% 3	5	5.00
Prolong life	60.00% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	40.00% 2	5	3.40
Provide a cure	40.00% 2	20.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	40.00% 2	5	3.60

Q23 On a scale of 1-10, with 1 being “no side effects” and 10 being “significant side effects”, if you were to consider taking a new therapy for your cancer, what severity of side effects would you be willing to tolerate in order to extend survival by 2 months, after having been told there is no other available treatment? For example, side effects such as: nausea, fatigue, vomiting, diarrhea.

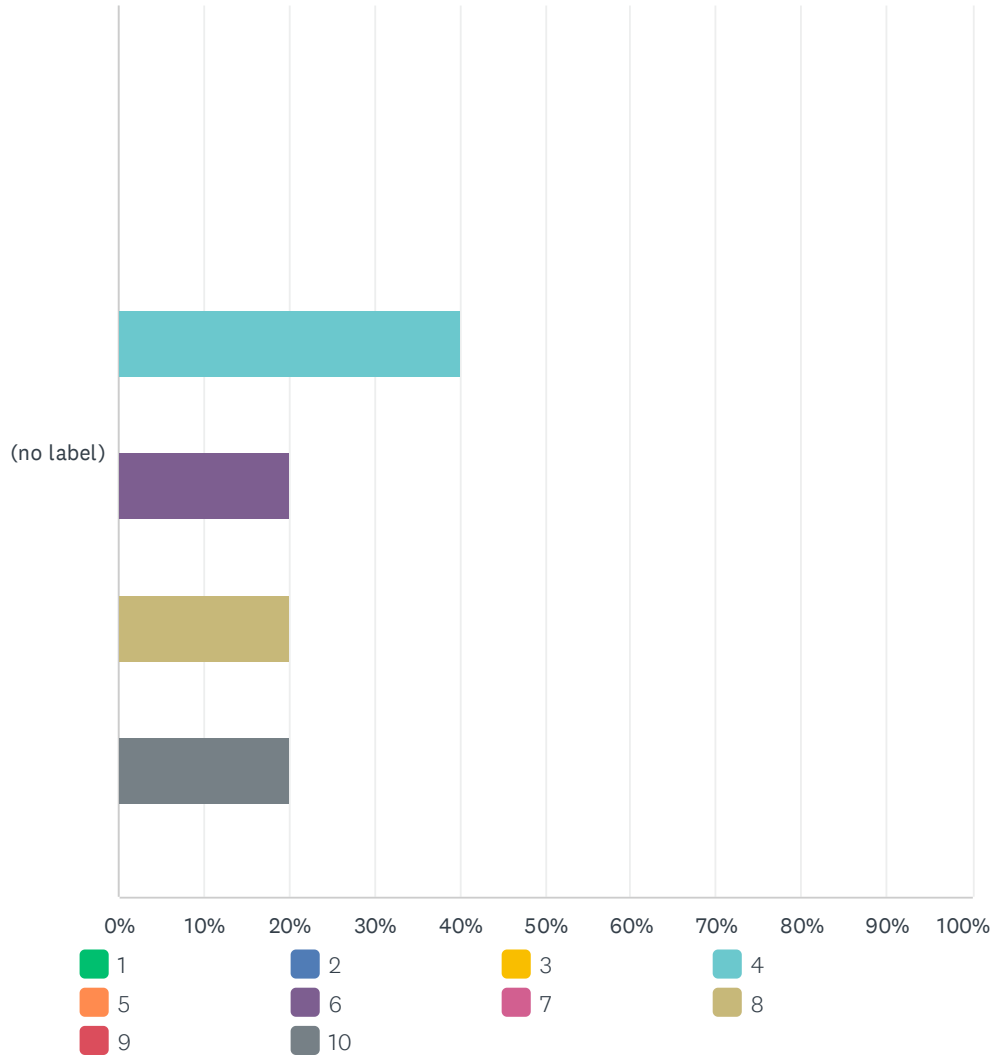
Answered: 5 Skipped: 1



	1	2	3	4	5	6	7	8	9	10	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	20.00% 1	20.00% 1	20.00% 1	0.00% 0	0.00% 0	20.00% 1	0.00% 0	0.00% 0	20.00% 1	5	5.20

Q24 On a scale of 1-10, with 1 being “no side effects” and 10 being “significant side effects”, if you were to consider taking a new therapy for your cancer, what severity of side effects would you be willing to tolerate in order to extend survival by 6 months, after having been told there is no other available treatment? For example, side effects such as: nausea, fatigue, vomiting, diarrhea.

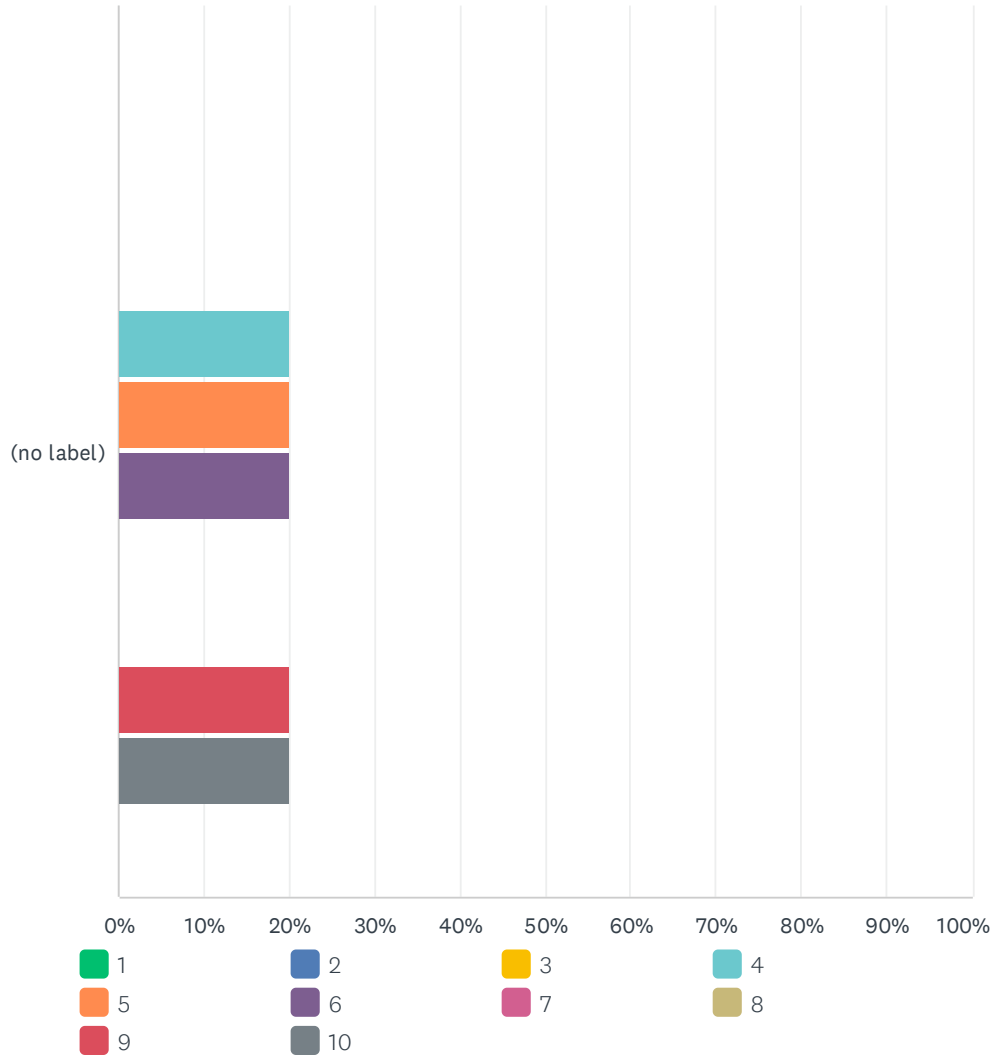
Answered: 5 Skipped: 1



	1	2	3	4	5	6	7	8	9	10	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	40.00% 2	0.00% 0	20.00% 1	0.00% 0	20.00% 1	0.00% 0	20.00% 1	5	6.40

Q25 On a scale of 1-10, with 1 being “no side effects” and 10 being “significant side effects”, if you were to consider taking a new therapy for your cancer, what severity of side effects would you be willing to tolerate in order to extend survival by 1 year, after having been told there is no other available treatment? For example, side effects such as: nausea, fatigue, vomiting, diarrhea.

Answered: 5 Skipped: 1



	1	2	3	4	5	6	7	8	9	10	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	20.00% 1	20.00% 1	20.00% 1	0.00% 0	0.00% 0	20.00% 1	20.00% 1	5	6.80

Q26 What considerations do you make when it comes to balancing the advantages and disadvantages of a treatment?

Answered: 3 Skipped: 3

#	RESPONSES	DATE
1	Quality of life, energy	10/29/2023 3:29 PM
2	Longevity, How severe the other side effects are.	10/29/2023 1:28 PM
3	Quality of life, extending my life	10/28/2023 11:57 AM

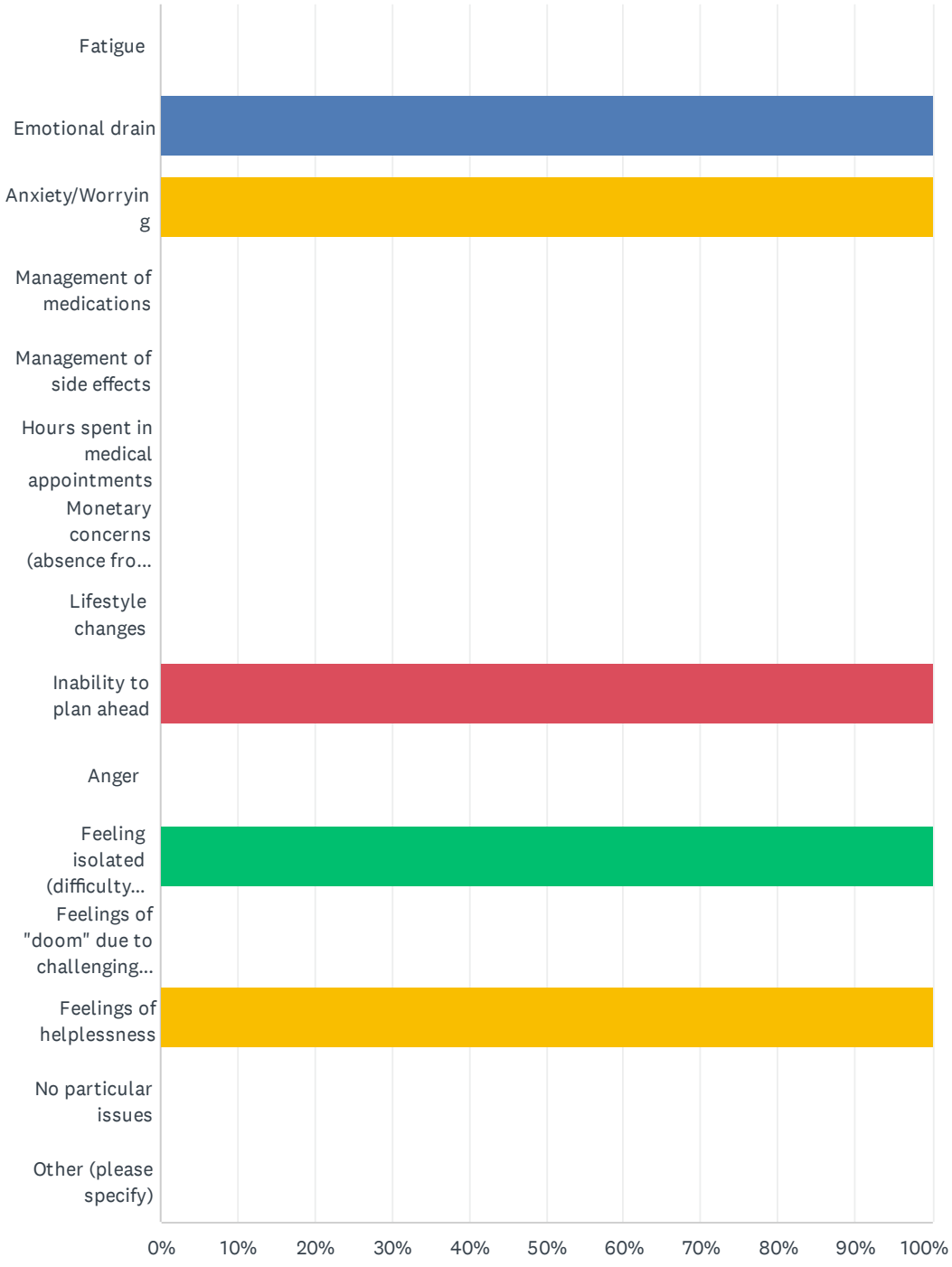
Q27 Is there anything else you would like to share with us about your cancer journey?

Answered: 3 Skipped: 3

#	RESPONSES	DATE
1	I was blessed to have unlimited support through the Cancer foundation of Canada. My radiation went very well. Everyone one was so helpful. I just felt very well cared for everywhere.	10/29/2023 1:28 PM
2	Cancer treatment care was great. Big drop of in care between my gp and gyne doctors. No help for after care.	10/28/2023 11:57 AM
3	I was referred for genetic testing because of family colo-rectal cancer history. However my tumour test was not MSI-High. A wise genetic counsellor encouraged me to have the DNA test regardless which I did. Results were positive for Lynch Syndrome. Subsequently my surviving brother and one of my 2 daughters have also tested positive. A second MSI Tumour test requested by the the genetic counsellor confirmed the original test results. This was not the first time in my now 35 year long cancer journey that I have had a “false negative” on a test. This can be disconcerting knowledge to have lived with as a now 80 year old.	10/28/2023 11:55 AM

Q28 What are the issues you encounter or have encountered as a caregiver for someone with endometrial cancer? Check all that apply.

Answered: 1 Skipped: 5

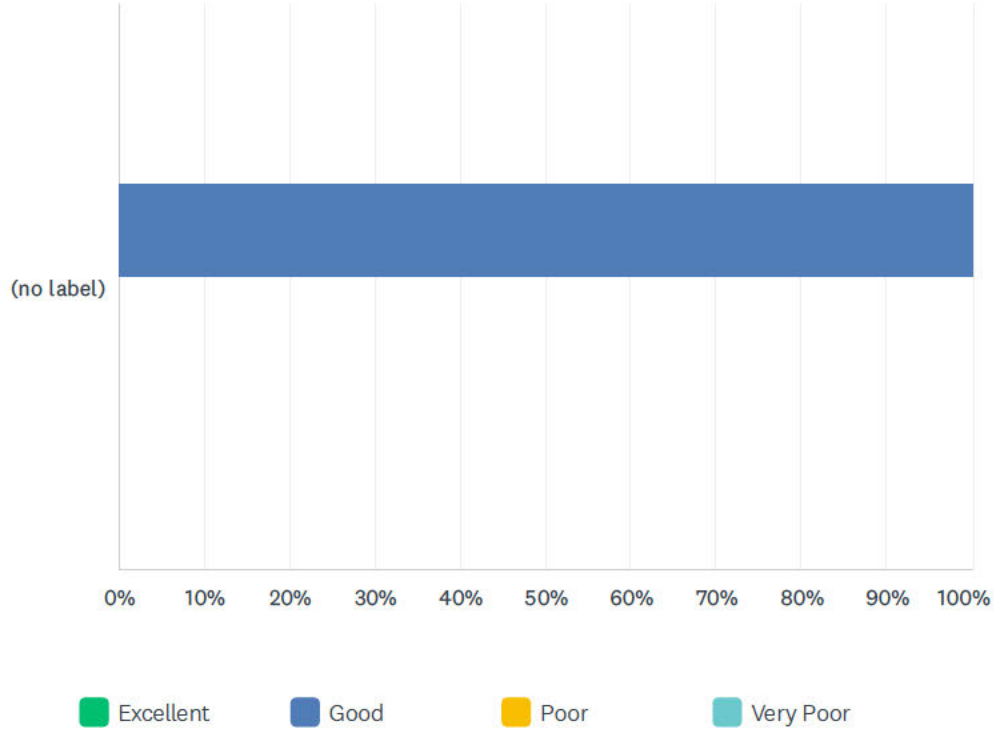


ANSWER CHOICES	RESPONSES	
Fatigue	0.00%	0
Emotional drain	100.00%	1
Anxiety/Worrying	100.00%	1
Management of medications	0.00%	0
Management of side effects	0.00%	0
Hours spent in medical appointments	0.00%	0
Monetary concerns (absence from work, driving expenses, etc.)	0.00%	0
Lifestyle changes	0.00%	0
Inability to plan ahead	100.00%	1
Anger	0.00%	0
Feeling isolated (difficulty connecting with friends, geographical remoteness)	100.00%	1
Feelings of "doom" due to challenging prognosis	0.00%	0
Feelings of helplessness	100.00%	1
No particular issues	0.00%	0
Other (please specify)	0.00%	0
Total Respondents: 1		

#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Q29 How would you rate the current treatments based on how they address the needs of endometrial cancer patients?

Answered: 1 Skipped: 5



	EXCELLENT	GOOD	POOR	VERY POOR	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	100.00% 1	0.00% 0	0.00% 0	1	2.00

Q30 How has caring for someone with endometrial cancer affected your daily routine or lifestyle?

Answered: 0 Skipped: 6

#	RESPONSES	DATE
	There are no responses.	

Q31 What are the most challenging adverse effects related to your loved one and their current therapy or treatment?

Answered: 1 Skipped: 5

ANSWER CHOICES	RESPONSES	
None	0.00%	0
Anxiety/Worry	0.00%	0
Emotional drain	0.00%	0
Management of medications	0.00%	0
Management of treatment-induced side effects	100.00%	1
Time spent at medical appointments	0.00%	0
Loss of income	0.00%	0
Lifestyle changes	100.00%	1
Inability to plan ahead for future	100.00%	1
Emotional toll on family	0.00%	0
Feelings of helplessness because I cannot help my loved one feel better	100.00%	1
Feelings of doom	0.00%	0
Other (please specify)	0.00%	0
Total Respondents: 1		

#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Q32 What would you most like to see out of a new treatment for patients with endometrial cancer?

Answered: 0 Skipped: 6

#	RESPONSES	DATE
	There are no responses.	

Q33 Is there anything else that you would like to share with us about your experiences as a caregiver?

Answered: 0 Skipped: 6

#	RESPONSES	DATE
	There are no responses.	

Q34 If you are interested in being contacted as a patient or a caregiver, to provide further information, please leave your contact information below.

Answered: 2 Skipped: 4

ANSWER CHOICES	RESPONSES	
Name	100.00%	2
Company	0.00%	0
Address	0.00%	0
Address 2	0.00%	0
City/Town	0.00%	0
State/Province	0.00%	0
ZIP/Postal Code	0.00%	0
Country	100.00%	2
Email Address	100.00%	2
Phone Number	100.00%	2

#	NAME	DATE
1	eleanor lester	10/29/2023 3:29 PM
2	Joan	10/28/2023 11:57 AM

#	COMPANY	DATE
	There are no responses.	

#	ADDRESS	DATE
	There are no responses.	

#	ADDRESS 2	DATE
	There are no responses.	

#	CITY/TOWN	DATE
	There are no responses.	

#	STATE/PROVINCE	DATE
	There are no responses.	

#	ZIP/POSTAL CODE	DATE
	There are no responses.	

#	COUNTRY	DATE
1	canada	10/29/2023 3:29 PM
2	Canada	10/28/2023 11:57 AM

#	EMAIL ADDRESS	DATE
1	[redacted]	10/29/2023 3:29 PM
2	[redacted]	10/28/2023 11:57 AM

#	PHONE NUMBER	DATE
1	[redacted]	10/29/2023 3:29 PM
2	[redacted]	10/28/2023 11:57 AM

CCRAN Colorectal Cancer Resource & Action Network | RISCC Réseau d'informations et soutien pour le cancer colorectal

A PATIENT-FOCUSED ORGANIZATION

CANADIAN CANCER SURVIVOR NETWORK | RÉSEAU CANADIEN DES SURVIVANTS DU CANCER

ARE YOU A LOCALLY ADVANCED OR METASTATIC ENDOMETRIAL CANCER PATIENT WHO HAS RECEIVED OR IS RECEIVING *DOSTARLIMAB (JEMPERLI)* IN COMBINATION WITH CHEMOTHERAPY?

IF SO, WE *REALLY NEED YOUR HELP!*

Dostarlimab therapy is currently under a funding review in Canada for the treatment of advanced or metastatic endometrial cancer, regardless of MMR or MSI status, and we could surely use your help as a patient who has firsthand experience with this therapy, or as a caregiver on the patient's behalf.

Would you be willing to participate in a phone interview to help capture your lived experience with the therapy and cancer journey, so that we may include your anonymized details in our submission to the expert committees overseeing the drug funding recommendations in Canada?

Patients and caregivers may consent to have their contact information (name, phone # and email address) sent to Filomena Servidio and, in turn, the patient/caregiver will be contacted with an appointment time and date for participation in the telephone interview.

Alternatively, the patient/caregiver may contact Filomena directly, ASAP, to advise of their willingness to participate in a telephone interview to help inform the patient input submission and help to make a meaningful impact on our submission:

[redacted]

Please contact us ASAP to schedule the 45 minute phone interview.

Thank you for making a difference in the lives of endometrial cancer patients and their families!

We look forward to hearing from you!

CADTH

CADTH Reimbursement Review

Clinician Group Input

CADTH Project Number: PC0381-000
Generic Drug Name (Brand Name): dostarlimab (Jemperli)
Indication: In combination with carboplatin and paclitaxel for the treatment of adult patients with primary advanced or recurrent endometrial cancer who are candidates for systemic therapy.
Name of Clinician Group: OH (CCO) Gynecologic Cancer Drug Advisory Committee
Author of Submission: Dr. Sarah Ferguson

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

Current treatments include platinum-based chemo (usually carboplatin-paclitaxel), radiation.

Treatment goals include to prolong life, delay disease progression, reduce symptoms, improve health-related Qo, and potentially cure disease.

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.

There is no other treatment other than carboplatin-paclitaxel and it does not produce a durable response. Therefore there is a need for new therapy to improve oncologic outcomes and prolong life.

5. Place in Therapy

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

This will be used in first line with chemotherapy, followed by maintenance, as well as in the platinum-sensitive recurrent setting.

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 best suited include dMMR patients as they have best PFS and significant OS benefit.

Patients least suited are those with a contradiction to immunotherapy or poor ECOG status.

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?

Combination of imaging and clinical exam as per physician discretion.

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

Progression of disease, intolerable toxicity

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]?

Outpatient settings under the care of physician who can give systemic therapy.

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. Sarah Ferguson
Position: Lead, OH (CCO) Gynecologic Cancer Drug Advisory Committee
Date: 05-08-2024

☒ **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

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.

CADTH

CADTH Reimbursement Review

Clinician Group Input

CADTH Project Number: **PC0381-000**
Generic Drug Name (Brand Name): **dostarlimab**
Indication: <Enter Response here>
Name of Clinician Group: **The Society of Gynecologic Oncology of Canada**
Author of Submission: Dr Lesley Roberts

1. About Your Clinician Group

Please describe the purpose of your organization. Include a link to your website (if applicable).

The Society of Gynecologic Oncology of Canada (GOC) is a national non-profit organization consisting of physicians, nurses, scientists, and other health care professionals specializing in gynecologic oncology. Our mission is to improve the care of women with or at risk of gynecologic cancer by raising standards of practice, promoting ongoing research, fostering innovation in prevention, care, and discovery, and increasing awareness. We work to disseminate knowledge to practitioners, patients, and the public and collaborate with other organizations committed to women's healthcare. For more information, please visit our website: The Society of Gynecologic Oncology of Canada – Voice of Gynecological Oncology (gyneoncology.ca)

2. Information Gathering

Please describe how you gathered the information included in the submission.

The information included in this submission is based on data from the RUBY trial (Mirza et al, 2023), further results presented at the Society of Gynecologic Oncology Annual Meeting in March 2023, and Canadian Cancer Statistics. It is also informed by the clinical experience of our members, who care for patients with gynecologic cancers in Canada.

3. Current Treatments and Treatment Goals

Please describe the current treatment paradigm for the disease.

- Focus on the Canadian context.
- Please include drug and non-drug treatments.
- Drugs without Health Canada approval for use in the management of the indication of interest may be relevant if they are routinely used in Canadian clinical practice. Treatments available through special access programs are relevant. Are such treatments supported by clinical practice guidelines?
- Do current treatments modify the underlying disease mechanism? Target symptoms?
- What are the most important goals that an ideal treatment would address?
- **Examples:** Prolong life, delay disease progression, improve lung function, prevent the need for organ transplant, prevent infection or transmission of disease, reduce loss of cognition, reduce the severity of symptoms, minimize adverse effects, improve health-related quality of life, increase the ability to maintain employment, maintain independence, reduce burden on caregivers.

The current treatment for pMMR endometrial cancer primarily includes surgery (with or without adjuvant radiation) for early-stage disease and chemotherapy (usually carboplatin and paclitaxel) for advanced or recurrent cases.

Immunotherapy is available only in combination with lenvatinib for recurrent disease, after prior chemotherapy, but there are no first-line immunotherapy options for Stage III-IV or recurrent pMMR endometrial cancer.

Key Treatment Goals:

- **Prolong survival**
- **Delay disease progression**
- **Improve response rates**
- **Maintain or improve quality of life**

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.

Please describe goals (needs) that are not being met by currently available treatments. Examples of unmet needs:

- Not all patients respond to available treatments
- Patients become refractory to current treatment options
- No treatments are available to reverse the course of disease
- No treatments are available to address key outcomes
- Treatments are needed that are better tolerated
- Treatments are needed to improve compliance
- Formulations are needed to improve convenience

Please describe limitations associated with current treatments (e.g., adverse events, administration, etc., if applicable).

Unmet Needs:

- **Current chemotherapy has limited effectiveness, especially in pMMR endometrial cancer.**
- **Immunotherapy is not available as a first-line treatment for advanced pMMR cases.**
- **Patients with pMMR advanced or recurrent disease have poorer outcomes compared to dMMR patients.**

Limitations of Current Treatments:

- **Chemotherapy alone results in poor response rates and survival outcomes for pMMR patients.**
- **Immunotherapy options are only available in later lines of therapy and have associated toxicity issues.**

5. Place in Therapy

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

Is there a mechanism of action that would complement other available treatments, and would it be added to other treatments?

Is the drug under review the first treatment approved that will address the underlying disease process rather than being a symptomatic management therapy?

Would the drug under review be used as a first-line treatment, in combination with other treatments, or as a later (or last) line of treatment?

Would the drug under review be reserved for patients who are intolerant to other treatments or in whom other treatments are contraindicated?

Is the drug under review expected to cause a shift in the current treatment paradigm?

Please indicate whether or not it would be appropriate to recommend that patients try other treatments before initiating treatment with drug under review. Please provide a rationale for your perspective.

Dostarlimab plus chemotherapy would provide the first immunotherapy option available as a first-line treatment for patients with advanced (Stage III or IV) or recurrent pMMR endometrial cancer. The RUBY trial demonstrated improved outcomes in progression-free survival (PFS) and overall survival (OS) compared to chemotherapy alone.

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?

Which patients are most likely to respond to treatment with drug under review?

Which patients are most in need of an intervention?

Would this differ based on any disease characteristics (e.g., presence or absence of certain symptoms, stage of disease)?

How would patients best suited for treatment with drug under review be identified (e.g., clinician examination/judgement, laboratory tests (specify), diagnostic tools (specify))

Are there any issues related to diagnosis?

Is a companion diagnostic test required?

Is it likely that misdiagnosis occurs in clinical practice (e.g., underdiagnosis)?

Is it possible to identify those patients who are most likely to exhibit a response to treatment with drug under review?

Patients with primary Stage III or IV or recurrent pMMR endometrial cancer would be best suited for dostarlimab plus chemotherapy, particularly those who have limited treatment options and are at risk of poor outcomes with chemotherapy alone.Are outcomes used in clinical practice aligned with the outcomes typically used in clinical trials?

What would be considered a clinically meaningful response to treatment? Consider the magnitude of the response to treatment. Is this likely to vary across physicians?

Examples: improved survival; reduction in the frequency/severity of symptoms (provide specifics regarding changes in frequency, severity, etc.); attainment of major motor milestones; ability to perform activities of daily living; improvement of symptoms; and stabilization (no deterioration) of symptoms.

Key outcomes include progression-free survival (PFS), overall survival (OS), and reduction in tumor burden as measured by imaging. Response rates and patient quality of life improvements are also important indicators of treatment success.

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

Examples: disease progression (specify, e.g. loss of lower limb mobility); certain adverse events occur (specify type/frequency/severity); or additional treatment becomes necessary (specify).

Treatment discontinuation may be necessary if there is disease progression, intolerable adverse events, or if the patient's condition deteriorates significantly.

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]?

Examples: Community setting, hospital (outpatient clinic), specialty clinic

If a specialist is required, which specialties would be relevant?

Dostarlimab plus chemotherapy should be administered in a hospital or specialty clinic where specialists in gynecologic oncology can closely monitor treatment and manage any side effects.

6. Additional Information

Is there any additional information you feel is pertinent to this review?

<Enter Response Here>

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.

   <Enter Response Here>

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.

   <Enter Response Here>

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: Lesley Roberts
Position: Director of Education
Date: 11/09/2024

☒ **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**
AstraZeneca 1 time Honorarium	X			
AbbVIe Advisory board				
Add or remove rows as required				

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

Declaration for Clinician 2

Name: <Enter full name>
Position: <Enter currently held position>
Date: <DD-MM-YYYY>

☐ 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

	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 3

Name: <Enter full name>
Position: <Enter currently held position>
Date: <DD-MM-YYYY>

☐ 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: <Enter full name>
Position: <Enter currently held position>
Date: <DD-MM-YYYY>

☐ 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

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 5

Name: <Enter full name>
Position: <Enter currently held position>
Date: <DD-MM-YYYY>

☐ 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 5: Conflict of Interest Declaration for Clinician 5

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.