CADTH REIMBURSEMENT REVIEW

Patient and Clinician Group Input

faricimab (Vabysmo)

Hoffmann-La Roche Limited

Indication: For the treatment of macular edema secondary to retinal vein occlusion (RVO).

June 17, 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: faricimab
Indication: Retinal vein occlusion
Name of Patient Group: Fighting Blindness Canada, The Canadian Council of the Blind, CNIB, Vision Loss Rehabilitation Canada
Author of Submission: Dr. Larissa Moniz (FBC), Dr. Keith Gordon (CCB), Thomas Simpson (CNIB), Jennifer Urosevic (VLRC)

1. About Your Patient Group

Fighting Blindness Canada (FBC) is the largest charitable funder of vision research in Canada. Over our 50-year history, FBC has contributed critical funding for the development of sight-saving treatments and cures for blinding eye diseases. By raising and stewarding funds, FBC is helping drive forward research that supports our goal of understanding why vision loss occurs, how it can be slowed and how sight can be restored. We are an invaluable resource for individuals and families impacted by blindness, providing accurate eye health information through our website and educational events, as well as engaging with government and other stakeholders to advance better vision health policies.

The Canadian Council of the Blind (CCB) is a membership-based not-for-profit organization that brings together Canadians who are blind, deaf-blind or living with vision loss through chapters within their own local communities to share common interests and social activities. CCB works to improve the quality of life for persons with vision loss through awareness, peer mentoring, socializing, sports, advocacy, health promotion and illness prevention. The CCB was founded in 1944 by blind Canadian war veterans and schools of the blind. The national office is located in Ottawa with over 80 chapters across Canada. The CCB is the largest membership-based organization for the blind in Canada and is known as the Voice of the Blind™.

Founded in 1918, **CNIB** is a non-profit organization driven to change what it is to be blind today. We deliver innovative programs and powerful advocacy that empower people impacted by blindness to live their dreams and tear down barriers to inclusion. Our work as a blind foundation is powered by a network of volunteers, donors and partners from coast to coast to coast.

Vision Loss Rehabilitation Canada (VLRC) is a health services organization. We provide training that enables people who are blind or partially sighted to develop or restore key daily living skills, helping enhance their independence, safety and mobility. Our certified specialists work closely with ophthalmologists, optometrists and other health care professionals, providing essential care on a referral basis in homes and communities. The Vision of VLRC is to maximize health and independence for Canadians impacted by vision loss and our mission is to provide high-quality, integrated and accessible rehabilitation and health care services that enable Canadians impacted by vision loss to live the lives they choose.

2. Information Gathering

Information was collected through an **online survey** made available to Canadians living with retinal vein occlusion (RVO) in March and April 2024. The survey was shared across networks associated with FBC, CCB and VLRC and distributed to patients with RVO by three Ontario based ophthalmologists. Our goal with the was to learn more about lived experiences of RVO and associated vision loss and treatments.

Information from the survey was supplemented with **qualitative interviews** held in March and April 2024 with three patients diagnosed with RVO. The interviews were semi-structured and included two patients who had experience with the drug under review.

Overview of Respondents

32 Canadians responded to the survey. The mean age of respondents was 69 years of age with roughly even numbers of male and female respondents. 52.9% of respondents were from Ontario (44.8%), followed by smaller percentages from British Columbia, Alberta, Newfoundland, Nova Scotia, Quebec and Saskatchewan. Overall, 70% of respondents live in urban areas, as determined by their postcode.

62.5% of respondents have central RVO, 21.9% have Branch RVO and 15.6% did not know what type of RVO they were diagnosed with. Most respondents (71.0%) have RVO in one eye only.

Table 1. Baseline characteristics of respondents (n = 32)

Characteristic	n (%)
Age (n = 28)	
Mean age (SD)	68.9 (13.9)
18 - 39 years	1 (3.6)
40 - 59 years	4 (14.3)
60 - 79 years	17 (60.7)
80+ years	6 (21.4)
Gender (n = 2)	
Female	15 (51.7)
Male	14 (48.3)
Province (n = 27)	
Ontario	14 (51.9)
British Columbia	6 (22.2)
Alberta	3 (11.1)
Newfoundland	1 (3.7)
Nova Scotia	1 (3.7)
Quebec	1 (3.7)
Saskatchewan	1 (3.7)
Location (n = 27)	
Urban	19 (70.0)

Rural	8 (29.6)
Employment Status (n = 28)	
Retired	17 (60.7)
Employed, full-time	5 (17.9)
Employed, part-time	3 (10.7)
Unemployed, due to vision loss	2 (7.1)
Unemployed	1 (3.6)
Ethnicity (n = 31)	
White	25 (80.6)
South Asian	2 (6.5)
Southeast Asian)	2 (6.5)
Arab	1 (3.2)
Metis	1 (3.2)

3. Disease Experience

53.2% of respondents were diagnosed with RVO one and four years ago, 15.6% five to nine years ago and 28.1% 10+ years ago, with a single respondent being diagnosed in the last year. The majority (74.2%) had symptoms which led to their diagnosis, most commonly blurry vision (51.6%), sudden vision loss (35.5%) or dark spots/lines (32.3%). 58.1% of respondents have one or more additional eye conditions including most commonly glaucoma or high pressure (29%) and retinal tears or detachment (19.4%).

On a scale of 0-10, where 0 is no vision and 10 is perfect vision, the average self-reported vision score was 5.6, with 3 participants rating their vision as 0 (no vision). 32.3% of respondents have been diagnosed as being legally blind. Since being diagnosed with RVO, 53% felt that their vision had gotten worse with 25% reporting vision improvement and 22% no change.

Respondents made clear that the disease has a significant impact on their day to day lives. When asked to rank the impact from 0-10 (where 0 was no impact and 10 was a major impact), the average score was 5.8 with 10% reporting no impact and 13% a major impact of RVO. RVO negatively impacted several areas, most notably reading (70%), driving (50%), hobbies (40%) and overall independence (30%). Respondents also identified modifications or aids that they now use because of vision loss including magnifiers (48%), books with enlarged font or audiobooks (31%), specialized software (21%) or canes or guide dogs (17%).

Beyond these day-to-day impacts, RVO affects patients psychologically in a profound way. For example, 53.3% or respondents have experienced anxiety because of their RVO diagnosis and approximately a third have experienced fear, anger and/or loss of confidence/self-worth (Table 2).

Table 2. Experiences due to RVO (n = 30)

Experience	n (%)
Anxiety	16 (53.3)
Fear	11 (36.7)
Anger	10 (33.3)
Stress	13 (43.3)
Loss of confidence or self-worth	10 (33.3)
Isolation or loneliness	8 (26.7)
Employment or educational barriers	6 (20.0)
Discrimination	3 (10.0)
None of the above	6 (20.0)
Other	3 (10.0)

Because of the sudden nature of RVO combined with its severity respondents expressed ongoing fear of progression or that the unaffected eye may one day be affected.

"They told me it was never going to happen again every time I saw somebody. "Don't worry, it's not going to happen." But about twenty years to the day, it happened again in the right eye" and *"I think the "what-if" is the hardest part. What if it gets worse, or if it happens to my other eye? I feel anxious about it."*

A few respondents felt anxiety and isolation because of the relative rarity of RVO meaning an individual may not know anyone else with the disease. It was also noted that getting a diagnosis can be lengthy and complicated since an ophthalmologist may not be the first point of contact and RVO awareness among other health care providers can be sub-optimal.

The impact on those of working age was particularly highlighted, encompassing lack of coverage of treatment, difficulty attending multiple appointments and the impact that vision loss has on the ability to continue in a career.

"*I was a professional musician for 39 years and when it happened, I thought "I'm not playing". So instantly out of the pool. What does a musician do when they can no longer play music? Who do you hang out with? I spent 4 months crying because I was no longer in symphony."*

"I have to work and with my job, I need to have medical testing and vision tests. And I shouldn't say this but I've memorized the eye chart. I know I shouldn't but that's what I have to do. I'm still young, I need to work."

4. Experiences With Currently Available Treatments

Overview of Treatment Experience

We asked questions about treatment experience (Table 3), with 60.0% of respondents having received anti-VEGF injections and another 20.0% receiving eye injections but not being able to identify the drug. 26.7% of respondents had also received laser treatment.

Table 3. Treatments received (n = 30)

Treatment	n (%)
Anti-VEGF injections in the eye (e.g. Eylea, Lucentis, Avastin)	18 (60.0)
Laser treatment	8 (26.7)
Steroid injections in the eye (e.g. Triescence, Kenalog)	1 (3.3)
I get eye injections but I'm not sure what type of medication	6 (20.0)
I've never received treatments for RVO	4 (13.3)
Other (please specify): *betoptic eyedrops*	1 (3.3)

We also asked how treatment cost was covered. With 83.3% receiving some form of provincial coverage. 16.7% relied at least partly on health insurance through work or a partner and 12.5% indicated covering at least some costs out of pocket. An additional 20.8% described other out of pocket costs including for transportation and hotel costs and for medical tests. 26 participants answered the question of how much they paid out of pocket in the last year for RVO treatment (Table 4).

Table 4. Out of pocket costs for RVO treatment in last year (n = 26)

Amount	n (%)
$0	12 (46.2)
$1-500	10 (38.5)
$501-1000	2 (7.7)
$1001-5000	1 (3.8)
$5001-10000	1 (3.8)

Experience with Eye Injections

We also asked questions specifically about the experience of receiving eye injections. Of the 23 individuals who had experience with injections, 78.3% were currently receiving them. Of those currently receiving injections, 70.6% had been receiving them for one to four years and 17.6% reporting having been receiving injections for 10+ years. On average, respondents were receiving 8 injections a year and roughly a third (34.8%) had someone else attend the eye appointments with them. Table 5 reports the type of drug received, with respondents able to select more than one option.

Table 5. Name of drug received by eye injection (n = 23)

Drug	n (%)
Eylea (aflibercept)	9 (28.1)

Lucentis (ranibizumab)	5 (15.6)
Avastin (bevacizumab)	5 (15.6)
Vabysmo (faricimab)	4 (12.5)
Beovu (brolicizumab)	1 (3.1)
I don't know	8 (25.0)

Emotional and Physical Effects

78% of those who received injections reported feeling pain or discomfort in the 24h after treatment and half of respondents (52.1%) found it stressful or difficult attending appointments. The main reasons for the stress were anxiety about injections (83%), symptoms from the injections (50%) and travel to appointments (33%).

The travel burden might be particularly acute for those who live outside urban areas with one respondent noting *"I wish I was able to receive treatment at my local hospital instead of driving once a month to a doctor one hour away, during winter months it's sometimes scary driving on northern Ontario highways."*

Treatment compliance is important to improve effectiveness and prevent further vision loss, yet of those currently receiving treatment 27.8% reported delaying, cancelling or missing an appointment in the last year. the reasons for missing an appointment included conflicts with work, other health issues, difficulty travelling or finding someone to attend the appointment with them and anxiety about the injection itself.

Satisfaction

Overall, 68% of respondents with experience with eye injections were satisfied with the injections. When asked why they were satisfied, individuals primarily expressed that the injections improved their vision or that their vision was stable because of treatment. For those who were unsatisfied, the pain or side effects after injections, lack of vision improvement and lack of coverage for drug of interest were cited.

The interviews also delved a bit deeper into treatment satisfaction. Appreciation expressed for the multiple options that were now available but also frustration that there wasn't equal coverage or access across provinces.

"*I'm pleased there are varieties now because that gives both the ophthalmologists and patient choices. It's what's driven me to really fight for others. Because way back when Lucentis was coming on the market and not approved by Nova Scotia, that's when my real fight for eyecare got started. As I said to our legislators, "If there was treatment when I needed it, I would not be here in front of you".*

There are absolutely limited options. I'm at my cliff. I'm paying to be at the cliff. I don't have any other options. And I'm fighting the government to even keep this option [Vabysmo]. If I lived in Ontario, I'd have it. And while I love the Vabysmo because it has the 2 ingredients and it gets me to 8 weeks, I don't have any other avenues. And I'm not…if this doesn't work….well, we'll cross this bridge when we get to it.

5. Improved Outcomes

We asked respondents what they would value in a new treatment (Table 6). Preventing or slowing further vision loss was considered as important as restoring vision with approximately 90% stating that both features were very important in a new treatment. A treatment with lower out of pocket costs, lower side effects or that required fewer injections was considered very important by approximately one third of respondents with ultimately the effectiveness of any treatment being paramount.

"I would love a treatment where I didn't have to go every 6 weeks. Every 3-4 months would be good because I'm working. Each time I get an injection, I have to take the day off work. So not having to do that as much would be good. But no, I'll go more frequently if that means I'm getting as much improvement as I can. I'd rather go more often for injections if that will help my eye the most."

Table 6. What features are important in a new drug

Feature	Very important n (%)	Important n (%)	Slightly important n (%)	Not important n (%)
Restoring vision that has been lost (n = 28)	25 (89.3)	2 (7.1)	1 (3.6)	0
A treatment with lower out of pocket costs (n = 25)	9 (36.0)	6 (24.0)	4 (16.0)	6 (24.0)
Preventing or slowing down further vision loss (n = 27)	25 (92.6)	1 (3.7)	1 (3.7)	0
A treatment that has fewer side effects (n = 26)	12 (46.2)	10 (38.4)	2 (7.7)	2 (7.7)
A treatment that requires less appointments (n = 26)	10 (38.5)	9 (34.6)	1 (3.8)	6 (23.1)
A treatment that is less invasive than an injection in the eye (n = 27)	11 (40.7)	8 (29.6)	7 (25.9)	1 (3.7)

6. Experience With Drug Under Review

Four of the survey respondents and two of the individuals interviewed had experience with faricimab the drug under review.

One patient who had switched from another anti-VEGF did not notice a difference after one injection but noted that their doctor saw a difference on an OCT scan.

"It's the same I think, not much difference in pain or anything else. I haven't noticed that my sight was better. I hoped it would be a miracle drug but it's not, I can't tell a difference. But I've only used it once. My doctor looked at the OCT scan and said "Oh! This is much better" so he can tell it looks better than it did with Avastin, but I can't tell. It's not like I thought it would be."

Another interviewee expressed hope, "*I was starting to get blind spots, and now I don't have those anymore [after treatment]."*

7. Companion Diagnostic Test

Not applicable

8. Anything Else?

The information garnered from the survey responses provide real patient experiences. RVO is a chronic disease that presents numerous challenges and burdens for patients, the survey found that among many challenges, RVO leads to visual complications that render certain daily activities – such as reading or driving – either problematic or impossible. In addition to causing diminishing visually acuity, RVO can present acute emotional and psychological burdens. Patients surveyed, indicated they experience elevated levels of fear or anxiety in relation to accelerated vision loss or when receiving their injection treatments. Patients noted that treatments with less demanding injection regimes would help ease some of the burden associated with RVO, when asked about experience of the disease and its treatment.

Due to advances in medical research, the use of anti-VEGF therapy by intravitreal injections has become common practice in the first line treatment of RVO patients, replacing surgical techniques that had discouraging outcomes. While the current anti-VEGF treatments on the market have shown high levels of effectiveness in slowing or halting vision loss, it also comes with the highly burdensome regular intravitreal injections creating challenges for many patients such as painfulness of the injection, both during and after the procedure, and their difficulties managing their bidirectional commute for their appointments. The journey becomes even more challenging for patients living in rural and remote parts of the country, travelling significantly long distances to their appointments with often inaccessible transportation for low vision individuals. The common theme of being robbed of their independence is one of the many challenges posed by RVO, which may lead to reliance and dependency on caregivers in travelling to and from appointments, and in managing daily living and tasks that are rendered very difficult by RVO and short-term visual complications due to intravitreal injections. Patients surveyed generally: would prefer treatment options that can be taken less frequently, and are supportive of treatments being made available regardless of which province they live in.

The recurring themes identified by patients, once more, strongly resonate and overlap with work our Organizations have done to understand lived experience of individuals with wet age-related macular degeneration, their experience with treatment and their overall journey as individuals who have to relearn how to live with independence due to vision complications and blindness.

These 32 individuals with RVO surveyed, have offered their voice, time, expertise, and insights to participate in this process and share their lived experiences helping to expand our understanding of how these individuals perceive their disease and treatments; the burdens that impact their lives, the barriers they face because of vision loss, and the psychological and emotional tolls of RVO. As Organizations that represent patients with eye conditions, like RVO, attributable to vision loss, our overarching goal is to contribute to the discussion meaningfully and strongly advocate for potential implementation of new treatments in this space. Along with individuals with RVO, our Organizations are here to guide discussions along lines that are patient-centered, equitable and with a focus on optimal outcomes: be it for patient access to affordable vision loss treatments that help individuals to live independently and that recognize the extremely important perspective of patients

with lived experience of RVO and their value in the review process of new treatments. For individuals with RVO it all boils down to “Nothing About Us Without Us”.

We look forward to continuing to work with CADTH to support individuals living with RVO, and to advance our collective understanding of how the disease and its treatments impact their lives.

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.

   FBC contracted JRL Research & Consulting to program and test the survey, perform qualitative interviews and clean and analyze the data.

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
Bayer				X
Novartis				X
Roche				X
Abbvie				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: Larissa Moniz, PhD
Position: Director, Research and Mission Programs
Patient Group: Fighting Blindness Canada
Date: June 13, 2024

Company	$0 to 5,000	$5,001 to 10,000	$10,001 to 50,000	In Excess of $50,000

Bayer				X
Novartis				X
Abbvie				X
Roche				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: Dr. Keith Gordon
Position: Senior Research Officer
Patient Group: The Canadian Council of the Blind
Date: June 12, 2024

Company	$0 to 5,000	$5,001 to 10,000	$10,001 to 50,000	In Excess of $50,000
Bayer				X
Novartis				X
Roche				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: Thomas Simpson
Position: Vice President, CNIB Voice
Patient Group: CNIB
Date: June 13, 2024

Company	$0 to 5,000	$5,001 to 10,000	$10,001 to 50,000	In Excess of $50,000
None to Declare				

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: Jennifer Urosevic
Position: President and CEO
Patient Group: Vision Loss Rehabilitation Canada
Date: June 10, 2024

CADTH Reimbursement Review

Clinician Group Input

CADTH Project Number: SR0832-000

Generic Drug Name (Brand Name): faricimab (Vabysmo)

Indication: For the treatment of macular edema secondary to retinal vein occlusion (RVO)

Name of Clinician Group: Northeastern Ontario Ophthalmology Group

Author of Submission: Dr. Stephen Kosar

1. About Your Clinician Group

Our group includes the following ophthalmologists practicing in Northeastern Ontario: Dr. Stephen Kosar (Sudbury), Dr. Alejandro Oliver (Timmins), Dr. Niranjan Vijay (North Bay - https://www.esno.ca/), Dr. Vanessa Ellies (North Bay - https://www.esno.ca/) and Dr. Alexander Soon (North Bay - https://www.esno.ca/). Our purpose is to deliver high quality ophthalmology care to residents of Northeastern Ontario.

2. Information Gathering

Our group compiled input via a virtual meeting, with support of a medical writer, and email.

3. Current Treatments and Treatment Goals

Current treatment for RVO secondary to macular edema consists mainly of anti-VEGF treatments and steroids. The main treatment goals are to reduce macular edema, improve vision, improve quality of life, and prevent complications. We strive to achieve these goals in the fewest visits possible (i.e. to reduce the burden of injections).

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.

Given the invasive nature of RVO treatment, drugs with a greater duration of action are needed to reduce the burden of injections for patients. Additionally, especially valuable in Northeastern Ontario where there are few ophthalmologists, fewer injections will help free up physician resources to treat more patients and reduce wait times. A treatment such as faricimab which reduces the burden of injections also helps reduce the barrier to care for physicians living in rural regions, far from ophthalmologist offices. Furthermore, the availability of additional effective therapies is valuable in optimizing patient care.

5. Place in Therapy

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

Faricimab will likely be used as a first line treatment given its efficacy and durability. It may also be used in second line following failure of existing approved therapies (due to lack of efficacy or observed toxicity) or in patients on a more frequent dosing interval of an existing approved/funded therapy.

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?

Faricimab would be a suitable treatment for all eligible patients with RVO, and not specific to any particular subgroup. Although infrequent, patients who experience an allergic reaction to an existing anti-VEGF treatment (e.g. aflibercept) may be prioritized to switch to faricimab. However, it is not possible to identify patients who are most likely to respond to faricimab.

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?

To determine treatment response, we assess clinical signs and symptoms, including OCT, visual acuity and patient-reported outcomes. This helps to determine if we should increase the time interval between injections. Response to treatment in patients with RVO is variable (more so than with AMD/DME) – some do not improve, others have responses which oscillate between improvement and decline – so even minor improvements in visual acuity (without complete resolution) while extending the treatment interval is considered a valuable treatment response in this disease area.

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

Outside of clinical response/safety, discontinuation of faricimab may occur due to patient-related factors such as better perceived efficacy on another therapy or difficulty travelling to the clinic for treatment.

5.5 What settings are appropriate for treatment with faricimab? Is a specialist required to diagnose, treat, and monitor patients who might receive faricimab?

Faricimab should only be administered by licensed ophthalmologists with experience in the diagnosis and treatment of retinal diseases and experience in injections.

6. Additional Information

The durability and associated extended dosing interval offered by faricimab is incredibly valuable to treatment of RVO, especially in Northeastern Ontario where physician resources are extremely limited.

If faricimab becomes reimbursed for this indication, it is important to not restrict funding to certain administration schedules – this should be at the physicians' discretion in order to provide the best care to patients.

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.

   Yes – we were supported by a third-party medical writer who recorded our discussion.

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 <u>each clinician</u> 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. Stephen Kosar

Position: Ophthalmologist

Date: 16-05-2024

☒ **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**
Bayer	X			
Novartis	X			

Declaration for Clinician 2

Name: Dr. Alejandro Oliver

Position: Assistant Professor of Ophthalmology

Date: 16-05-2024

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

Table 2: Conflict of Interest Declaration for Clinician 2

Company	Check appropriate dollar range*			
	$0 to $5,000	**$5,001 to $10,000**	**$10,001 to $50,000**	**In excess of $50,000**
Novartis	X			
Bayer	X			
Viatris	X			

Declaration for Clinician 3

Name: Dr. Vanessa Ellies

Position: Ophthalmologist

Date: 16-05-2024

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

Table 3: Conflict of Interest Declaration for Clinician 3

Company	Check appropriate dollar range*			
	$0 to $5,000	**$5,001 to $10,000**	**$10,001 to $50,000**	**In excess of $50,000**
Bayer	X			
Roche	X			

Declaration for Clinician 4

Name: Dr. Niranjan Vijay

Position: Chief of Ophthalmology, North Bay Regional Health Centre

Date: 16-05-2024

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

Table 4: Conflict of Interest Declaration for Clinician 4

Company	Check appropriate dollar range*			
	$0 to $5,000	**$5,001 to $10,000**	**$10,001 to $50,000**	**In excess of $50,000**
Bayer	X			
Roche	X			
Alcon	X			

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

Declaration for Clinician 5

Name: Dr. Alexander Soon

Position: Ophthalmologist

Date: 17-05-2024

☒ 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 5: Conflict of Interest Declaration for Clinician 5

	Check appropriate dollar range*			
Company	**$0 to $5,000**	**$5,001 to $10,000**	**$10,001 to $50,000**	**In excess of $50,000**
Bayer	X			
Roche	X			

CADTH Reimbursement Review

Clinician Group Input

CADTH Project Number: SR0832-000

Generic Drug Name (Brand Name): Faricimab (Vabysmo)

Indication: For the treatment of macular edema secondary to retinal vein occlusion (RVO)

Name of Clinician Group: Southeastern Ontario Community Ophthalmologists

Author of Submission: Dr. Adam McLaughlin

1. About Your Clinician Group

This physician group is comprised of 2 practicing ophthalmologists with community practice in Southeastern Ontario: Dr. Thomas Lee and Dr. Adam McLaughlin (both from Retina of Centre Ottawa (RCO) - http://www.ottawaretina.com/index.html).

Our group's purpose is to support continuous improvement of outcomes and optimal management of patients with retinal diseases.

2. Information Gathering

Information in this submission was gathered via phone and email, with the support of a medical writer to record input.

3. Current Treatments and Treatment Goals

The current Canadian treatment landscape for macular edema secondary to RVO is comprised mainly of anti-vascular endothelial growth factor (VEGF) with or without angiopoietin-2 (Ang-2) and steroid treatments administered as intravitreal injections into the eye. Therapeutic options are as follows:

- Aflibercept (EYLEA®) (2 mg/0.05 mL)
- Ranibizumab (LUCENTIS®)
- Bevacizumab (AVASTIN®) – **off-label for use in intraocular injections**
    - While off label, bevacizumab efficacy in clinical trials supports its use for RVO secondary to macular edema.
- Steroids (e.g. dexamethasone)
    - Note: the dexamethasone intravitreal implant (Ozurdex) is a treatment option that can provide extended treatment intervals but is associated with intraocular pressure spikes or glaucoma in ~20-30% of patients.

Physicians were hopeful to have brolucizumab as another treatment option to potentially extend the treatment intervals and reduce macular edema and ischemia for longer however, clinical trials have been paused due to safety concerns.

The main goals of treatment for macular edema secondary to RVO include:

- Extension of treatment intervals
- Reduction of macular edema
- Preservation of visual acuity
- Prevention of:
    - Neovascularization
    - Neovascular glaucoma

A significant proportion of patients with RVO require more frequent treatments (every 4, 5, 6, 7 or 8 weeks) regardless of the type of treatment. In these patients, treatment is time sensitive as even delaying treatment by a few days can significantly reduce their vision and increase their macular edema. We are hopeful for newer agents like faricimab to provide patients with another anti-VEGF and Ang-2 option to potentially extend the treatment interval.

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.

The key treatment goal is to extend the treatment interval as much as possible while maintaining efficacy. There is currently an unmet need for patients who are not achieving durable response on existing treatment options. Faricimab has demonstrated efficacy and a favourable safety profile, offering a valuable additional treatment option for patients, particularly as some existing treatment options introduce an added risk of additional conditions (e.g. pressure spikes and glaucoma) that need to be addressed.

5. Place in Therapy

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

We believe faricimab will make a great first-line treatment option for newly diagnosed patients and an additional option for those who are not achieving a durable response (experiencing treatment failure or plateau) with their active treatment.

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?

All patients with this disease requiring treatment with an anti-VEGF therapy would be suitable for this treatment.

There are no underlying patient characteristics that would cause us to consider faricimab over other treatments, aside from for those who are not responding well to their active treatment.

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?

Response to treatment is determined by:

- Stable or improved visual acuity
- Reduced presence of fluid via optical coherence tomography (OCT)
- Improved clinical exam measures of retinal hemorrhages, ischemia, neovascularization

Response assessment is aligned with clinical trials; however, fluorescein angiography (used to quantify how much ischemia/leakage is present) is not as readily available to ophthalmologists in all centres.

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

The factors impacting the decision to discontinue faricimab apply to all treatment options and include the following:

- If the patient is responding well and extension of treatment has increased to 4 months or more, we then assess whether it is reasonable to stop treatment and undergo close observation.
- If the patient's treatment interval declines or they experience progressive vison loss, a new treatment option should be considered.

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]?

Faricimab is only used in private- or hospital-based clinical settings. Diagnosis requires the expertise of an eye care professional such as an ophthalmologist or optometrist which is then confirmed by a retinal specialist.

6. Additional Information

Given the variability in treatment response for patients with RVO, it would be beneficial to have another potential agent that might afford some patients a longer treatment-free period or improved vision.

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.

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

   Yes. A third-party (non-pharmaceutical company) communications agency was used to manage logistics and record clinician group input.

5. 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.

6. 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: Thomas Lee, MD, FRCSC

Position: Clinical Assistant Professor, Department of Ophthalmology, University of Ottawa and The Ottawa Hospital; Retina Specialist, Retina of Centre Ottawa

Date: 22-05-2024

☒ 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 2

Company	Check appropriate dollar range*			
	$0 to $5,000	**$5,001 to $10,000**	**$10,001 to $50,000**	**In excess of $50,000**
Roche	X			
Bayer	X			

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

Declaration for Clinician 2

Name: John Adam McLaughlin, MD, JD, FRCSC
Position: Clinical Assistant Professor, Department of Ophthalmology, University of Ottawa and The Ottawa Hospital; Retina Specialist, Retina of Centre Ottawa

Date: 23-05-2024

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

Table 2: Conflict of Interest Declaration for Clinician 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**
Roche	X			
Bayer	X			
Apellis	X			

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

CADTH Reimbursement Review

Clinician Group Input

CADTH Project Number: SR0832-000

Generic Drug Name (Brand Name): Faricimab (Vabysmo)

Indication: For the treatment of macular edema secondary to retinal vein occlusion (RVO)

Name of Clinician Group: Southwestern Ontario Community Ophthalmologists

Author of Submission: Dr. Jaspreet Rayat

1. About Your Clinician Group

We are a group of community-based ophthalmologists practicing in Southwestern Ontario. Our group includes: Dr. Richard Weinstein, Dr. Jaspreet Rayat and Dr. Carl Shen from the Ocular Health Centre in Kitchener (https://www.ocularhealthcentre.ca/). Our purpose is to provide patients in Southwestern Ontario with optimal ophthalmology care.

2. Information Gathering

This reimbursement review was completed by a virtual meeting and email with the support of a medical writer to record input.

3. Current Treatments and Treatment Goals

For macular edema secondary to RVO in Canada, we mainly use anti-vascular endothelial growth factor (VEGF) as first-line treatment and intravitreal steroid treatments in second-line. Current therapeutic options are as follows:

- Aflibercept (EYLEA®) (2 mg/0.05 mL)
- Ranibizumab (LUCENTIS®)
- Bevacizumab (AVASTIN®)
    - Used off-label for intraocular injections
- Steroids
    - Steroids (e.g. subtenon Kenalog) can be injected intravitreally or in the form of a pellet (can stay in the eye longer but not covered by OHIP) however, steroids come with a lot of side effects, and we would prefer to use another anti-VEGF agent.

We are excited to have another agent on the market that works on two pathways: VEGF and inflammatory pathways via Ang-2. RVO has a large inflammatory component, and some studies have demonstrated the Ang-2 pathway is more active in these patients and may have a better response to faricimab.

We anticipate faricimab will require less injections which would therefore reduce the frequency of patient visits, cost, and burden on the healthcare system.

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.

Faricimab will be the first bispecific inhibitor blocking both VEGF and Ang-2. As a result, we anticipate patients will have a greater response to faricimab and require less frequent injections.

Currently, if patients with RVO secondary to macular edema fail other anti-VEGF treatments, they may be required to see an ophthalmologist every 2 months for the rest of their life because there are no other options. In our practice, patients with RVO can often have a positive response with treatment extension of available anti-VEGF therapies up to 8 weeks; however, response drops significantly if extended further. Any improved treatment durability, even if only extending treatment intervals by 1-2 weeks, will improve the quality of life of patients and their care givers by having less frequent and overall fewer injections.

Based on the studies of faricimab in patients with RVO so far, we are not expecting any issues with adverse events as the side effect profile is similar to other anti-VEGF agents on the market.

5. Place in Therapy

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

We believe faricimab would be a great first-line option for newly diagnosed patients with RVO based on the bispecific mechanism of action which is anticipated to generate a greater response. Faricimab will further expand the options of patients who fail other anti-VEGF treatments.

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?

Faricimab would be suited for any patient with RVO, particularly those who have failed to respond to other treatment options. However, we would be cautious in patients who have inflammation from other pre-existing conditions.

We do not anticipate any patients would be misdiagnosed, as the presence of fluid in the retina is clearly identifiable through OCT. Additionally, were it to be misdiagnosed as another condition related to fluid in the retina (e.g. AMD, DME), the treatments options are the same across all diseases (i.e. anti-VEGF agents, steroids). Therefore, we are not concerned about treating misdiagnosed patients with faricimab.

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?

The following outcomes are used to determine whether a patient is responding to treatment in clinical practice:

- Reduction in the heme or blood leaking into the eye.
- Reduced macular edema on an OCT scan.
- Improved vision.
- Fewer injections required/increased interval between injections.

Overall, any improvement in swelling determined with an OCT scan is considered a clinically meaningful improvement.

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

The factors that should be considered when deciding to discontinue faricimab are the same as any anti-VEGF which include lack of efficacy and development of inflammation or swelling which is extremely rare.

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]?

Any ophthalmologist who is experienced with injections and has access to an OCT would be able to diagnose, treat and monitor patients who might receive faricimab.

6. Additional Information

Current treatments do not work for all patients and right now, we are limited in the number of agents we can try. Adding another treatment option will give many of our patients hope, as we currently have a lot of patients with RVO who have failed available treatments and are waiting to try faricimab.

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.

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

   Yes. We were supported by a third-party medical writer who recorded our discussion.

8. 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.

9. 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. Jaspreet S Rayat

Position: Assistant Clinical Professor Adjunct, McMaster University, Co-Owner of Ocular Health Centre

Date: 16-05-2024

☒ **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**
Bayer	X			
Novartis	X			
Bausch + Lomb	X			

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

Declaration for Clinician 2

Name: Richard Weinstein M.D.

Position: Ophthalmologist, Co-founder of Ocular Health Centre

Date: 16-05-2024

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

Table 2: Conflict of Interest Declaration for Clinician 2

Company	Check appropriate dollar range*			
	$0 to $5,000	**$5,001 to $10,000**	**$10,001 to $50,000**	**In excess of $50,000**
Bayer	X			
Novartis	X			
Bausch + Lomb	X			

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

Declaration for Clinician 3

Name: Dr. Carl Shen

Position: Physician

Date: 16-05-2024

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

Table 3: Conflict of Interest Declaration for Clinician 3

	Check appropriate dollar range*			
Company	**$0 to $5,000**	**$5,001 to $10,000**	**$10,001 to $50,000**	**In excess of $50,000**
N/A – no COI to declare				

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

CADTH Reimbursement Review

Clinician Group Input

CADTH Project Number: SR0832-000

Generic Drug Name (Brand Name): Faricimab (VABYSMO)

Indication: Macular Edema Secondary to Retinal Vein Occlusion (RVO)

Name of Clinician Group: Toronto Retina Institute

Author of Submission: Dr Shaheer Aboobaker

1. About Your Clinician Group

We, the Toronto Retina Institute, are a group of 10 retina specialists in multiple locations across the GTA. (https://www.torontoretinainstitute.com/#/) We strive to ensure full spectrum retinal service to our patient base and strive to maintain excellence in medical and surgical care.

This submission is supported by the following physicians from our group:

Dr Shaheer Aboobaker

2. Information Gathering

The information in this submission was obtained through individual and shared clinician input via email and internal discussion.

3. Current Treatments and Treatment Goals

Current treatment protocols for Retina Vein Occlusion (RVO) involve treatment with antiVEGF therapies as a primary treatment in the context of macula edema secondary to the vein occlusion. Currently available treatments for this in Canada include aflibercept (EYLEA®), ranibizumab (LUCENTIS®) and brolucizumab (BEOVU®). Bevacizumab (AVASTIN®) may be used off label (not approved for RVO) but would not routinely be a first line therapeutic agent. All of these agents have been shown to be effective in treating macula edema secondary to RVO in clinical trials and real world contexts.

AntiVEGF therapy, as the mainstay of treatment, modifies the disease process by reducing the concentration of Vascular Enodthelial Growth Factor in the vitreous cavity, thus reducing the vascular leakage that arises as a result of the increased VEGF secretion in this disease context. This, in turn, reduces macula edema and can improve visual acuity. An ideal treatment in this condition would be efficacious at reducing VEGF levels, improve visual acuity, sustain improvements in visual acuity over the long term and be durable to reduce the treatment burden associated with ongoing intravitreal therapy.

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.

Treatments for RVO are mostly not curative; treatment is therefore ongoing and requires repeat visits with trained clinicians to receive injections into the eye. In addition to the burden on ophthalmology clinics and the healthcare system, this burden extends to patients and caregivers, causing inconvenience and the need to take time off work for appointments. While proper education and positive experience helps promote patient compliance, the notion of receiving frequent injections into the eye for years can be quite

onerous for patients.

Considering the aging population, the incidence of RVO and demand for these treatments is expected to rise. The limited number of retinal specialists who can administer these treatments will not sufficiently meet the demand.

These factors highlight the need for a treatment which is as efficacious but more durable/long-lasting than current therapies. Faricimab has been shown in phase 3 clinical trials, as well as in initial real world experience in other diagnostic indications (DME and nAMD), to reduce the injection frequency for our patients in a meaningful way and we expect to see a similar effect in RVO.

5. Place in Therapy

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

Currently, aflibercept 2 mg (EYLEA®) is the most common first-line treatment choice for patients who have financial coverage. We expect Faricimab would rapidly replace Aflibercept, becoming the new preferred first-line agent and standard of care. Given the longer dosing interval, Faricimab may also be chosen preferentially over ranibizumab for first-line treatment. It is unlikely patients who are already on treatment at a convenient and less frequent dosing interval would be switched to Faricimab, to avoid perturbing disease control.

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?

All patients eligible for treatment would be suitable for Faricimab. While misdiagnosis may rarely occur in clinical practice, diagnostic paradigms will not be impacted by the introduction of Faricimab. Patients with macula edema and a decrease in visual acuity would be in need of intervention, and this is usually a large proportion of the cohort diagnosed with RVO. Patients would be identified clinically and via OCT imaging.

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?

Response assessment is the same in clinical practice as in trials and includes the return to both normal anatomy (i.e. decrease in excessive retinal thickness or fluid accumulation) and visual acuity.

Clinicians utilize the treat-and-extend protocol to determine if the interval between treatments can be increased and treatment response approaches are fairly standardized across the retinal community

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

The decision to discontinue Faricimab is the same as with other currently available treatments. No response, while unlikely, or the presence of irreversible macular damage would lead to discontinuation, or a switch in regimen, given the risks (although small) associated with each injection. Patients who had an inflammatory event, again reported low risk across all indications thus far in clinical trials and real world experience, would likely facilitate a switch to an alternate agent.

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]?

Faricimab can be administered in any outpatient office setting (i.e. does not require an operating room), and should preferably be administered by fellowship-trained retinal specialists.

6. Additional Information

As the retina community moves towards a new era of injectable treatment for dry AMD, we must be acutely aware of the significant tidal wave of increased demand for these treatments, which will put significant strain on the existing capacity of an already overburdened system. Short of increasing training, recruitment and retention of fellowship trained retinal specialists to be able to deliver this care, newer treatment options like Faricimab offer the potential for a more durable treatment, leading to reduced treatment frequency, beyond currently available options, allowing for increased capacity building within the current resource limitations that exist.

7. Conflict of Interest Declarations

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

    No

11. 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

12. 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 <u>each clinician</u> 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: Shaheer Aboobaker

Position: Managing Partner, Toronto Retina Institute

Date: 19-04-2024

☒ **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**
Bayer		x		
Roche			x	
Novartis	x			
Teva	x			
Apobiologix	x			

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

Declaration for Clinician 2

Name: Alan Berger

Position: President and Co-founder, Toronto Retina Institute

Date: 19-04-2024

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

Table 2: Conflict of Interest Declaration for Clinician 2

Company	Check appropriate dollar range*			
	$0 to $5,000	**$5,001 to $10,000**	**$10,001 to $50,000**	**In excess of $50,000**
Bayer	x			
Roche	x			

Biogen	x			

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

Declaration for Clinician 3

Name: Keyvan Koushan

Position: Treasurer, Toronto Retina Institute

Date: 19-04-2024

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

Table 3: Conflict of Interest Declaration for Clinician 3

	Check appropriate dollar range*			
Company	**$0 to $5,000**	**$5,001 to $10,000**	**$10,001 to $50,000**	**In excess of $50,000**
Bayer	x			
Novartis	x			
Alcon	x			
Allergan	x			
Apellis	x			

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

Declaration for Clinician 4

Name: David Chow

Position: Vice-President and Co-founder, Toronto Retina Institute

Date: 19-04-2024

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

Table 4: Conflict of Interest Declaration for Clinician 4

	Check appropriate dollar range*			
Company	**$0 to $5,000**	**$5,001 to $10,000**	**$10,001 to $50,000**	**In excess of $50,000**
Alcon			x	
Roche			x	
Bayer		x		
Novartis	x			
Allergan	x			
Apellis	x			
Teva	x			
Biogen	x			

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