Canada's Drug Agency
L'Agence des médicaments du Canada

CDA-AMC REIMBURSEMENT REVIEW

Patient and Clinician Group Input

glofitamab (Columvi)

(Hoffmann-La Roche Limited)

Indication: Columvi (glofitamab for injection) in combination with gemcitabine and oxaliplatin for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are not candidates for autologous stem cell transplant (ASCT).

March 24, 2025

This document compiles the input submitted by patient groups and clinician groups for the file under review. The information is used by CDA-AMC 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. **If your group has submitted input that is not reflected within this document, please contact Formulary-Support@cda-amc.ca.**

Disclaimer: The views expressed in this submission are those of the submitting organization or individual. As such, they are independent of CDA-AMC and do not necessarily represent or reflect the views of CDA-AMC. No endorsement by CDA-AMC is intended or should be inferred.

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CDA-AMC does use reasonable care to prevent disclosure of personal information in posted material; however, it is ultimately the submitter's responsibility to ensure no identifying personal information or personal health information is included in the submission. The name of the submitting group and all conflicts of interest information from individuals who contributed to the

CADTH

CADTH Reimbursement Review
Patient Input Template

Patient Input Template for CADTH Reimbursement Reviews

Name of Drug: Glofitamab (Columvi)

Indication: Columvi (glofitamab for injection) in combination with gemcitabine and oxaliplatin for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are not candidates for autologous stem cell transplant (ASCT).

Name of Patient Group: Lymphoma Canada

Author of Submission: Gurjot Basra, Manager of Patient Programs, Research, and Advocacy

1. About Your Patient Group

Lymphoma Canada is a national Canadian registered charity whose mission it is to empower patients and the lymphoma community through education, support, advocacy, and research. Based out of Mississauga (ON), we collaborate with patients, caregivers, healthcare professionals, and other organizations and stakeholders, to promote early detection, find new and better treatments for lymphoma patients, help patients access those treatments, learn about the causes of lymphoma, and work together to find a cure. Resources are provided in both English and French. www.lymphoma.ca

2. Information Gathering

The data presented in this submission was collected from an online anonymous patient survey, created and promoted by Lymphoma Canada (LC) available from February 24 – March 23 2025. The survey link was promoted via e-mail to patients registered in the LC national emailing list and made available via social media outlets, including Twitter, Instagram, and Facebook accounts. The survey had a combination of multiple choice, rating, and open-ended questions. Skipping logic was built into the survey so that respondents were asked questions only relevant to them. Open-ended responses were noted in this report verbatim, to provide a deeper understanding of patient perspectives. 41 responses were collected. Information from this survey was used to identify the main areas of concern for patients with Diffuse Large B-cell lymphoma, with 2 confirmed responses for experience with Glofitamab (Columvi) in combination with gemcitabine and oxaliplatin for their Diffuse Large B-Cell Lymphoma (second line or greater). Both of these patients were male, lived in the United States, with an age range of 45-54 years.

Please see tables 1-4 below for demographic and relevant information of all survey respondents. The majority of patients lived in Canada (80%), between the age of 65 and 74 (40%), male (60%), and were diagnosed 1-2 years ago (26%), less than 1 year ago (22%), or 3-5 years ago (22%).

Table 1: Country of respondents from Lymphoma Canada survey

Respondents	CAN	USA	Skipped	Total
Patients with Large B-cell lymphoma	8	2	31	41

Table 2: Age range of respondents from Lymphoma Canada survey

Respondents	Age (years old)								
	18-24	25-34	35-44	45-54	55-64	65-74	75-84	Skipped	Total
Patients with Large B-cell lymphoma	1	0	1	1	1	4	2	31	41

Table 3: Gender of respondents from Lymphoma Canada survey

Respondents	Gender			
	Female	Male	Skipped	Total
Patients with Large B-cell lymphoma	4	6	31	41

Table 4: Number of years ago respondents were diagnosed with Large B-cell Lymphoma

Respondents	Years						
	<1	1-2	3-5	5-8	9-10	Skipped	Total
Patients with Large B-cell lymphoma	5	6	5	3	4	18	41

Table 5: Subtype of Large B-cell lymphoma of survey respondents

Subtype of Large B-cell Lymphoma	Number of respondents
Diffuse Large B-cell Lymphoma, not otherwise specified	13
DLBCL arising from follicular lymphoma	7
DLBCL arising from primary mediastinal B-cell lymphoma	1

DLBCL arising from Richter's transformation	1
Germinal center B-cell Lymphoma	1
Skipped	18
Total	41

3. Disease Experience

At Diagnosis

Through the online survey, patients were asked to rate a list of physical symptoms on a scale of 1 (no impact) to 5 (significant impact) in regards to their quality of life upon diagnosis. The most common reported symptoms rated as a four or five were: Fatigue/lack of energy (52%), neutropenia (31%) enlarged lymph nodes (30%), night sweats (30%), shortness of breath (26%), bodily aches and pains (26%), reduced appetite (26%), and weight loss (26%).

Respondents of the survey were also asked to select from a list of psychosocial impacts they experienced when diagnosed with DLBCL. Of the 23 patients who answered the question, 74% were impacted by anxiety/worry, fear of progression (65%), difficulty sleeping (52%), stress of diagnosis (43%), problems concentrating (35%), and inability to continue daily activities (35%). When asked to provide additional details about the challenges faced during diagnosis, comments were as follows:

- "I was diagnosed during the pandemic, so had to attend all appointment's alone. I struggled with a lot of isolation".
- "Always feeling tired"
- "Diagnosed at the beginning of Covid 19 pandemic. No masks, hand sanitizers available, what was going to happen? Terrified"
- "There was a delay in diagnosis because of being misdiagnosed initially when lymph nodes swelled."
- "I had a lot of scan anxiety"
- " Needing blood transfusions due to bone marrow being compromised by the DLBCL. Had to take a break from running (running was an outlet for physical and mental well being; Often attended a weekly run club with friends before diagnosis)"
- "Was very anxious to get started with therapy (R-CHOP + radiation) and extremely impressed with the professional approach of the oncology teams."
- "The diagnosis was about 3 months into the Covid-19 shut down, and I experienced severe mid back pain, I was hospitalized for 8 days as a result of this pain, while trying to figure out the nature of the disease and running diagnostic tests"

Current Quality of Life

To understand the factors which currently impact patients with Diffuse Large B-cell lymphoma, respondents were asked a similar style of questions from the diagnosis section of the survey. On a scale of 1 (no impact) to 5 (significant impact), 21% of patients rated fatigue as a 5 and 14% rated enlarged lymph nodes and anemia as a 5. Patients also indicated they recently experienced mental health challenges such as fear of progression/relapse (64%), anxiety/worry (57%), difficulty sleeping (50%), stress of having cancer (43%), and problems concentrating (36%).

Daily Activities

Regarding day-to-day activities, patients with Diffuse Large B-cell lymphoma rated several factors on a scale of 1 (no impact) to 5 (very significant impact) which impacted their daily life. The ability to work, school and volunteer (36%), ability to contribute financially to household expenses (29%), and ability to travel (29%), were rated as a 4 or higher. Many patients left comments in this section and a selection of quotes are included below:

- “Fatigue by large, and feeling tired in mid afternoon, I feel more distracted than before, some anxiety/ very mild depression stemming from my inability to return to my same level of functioning”
- “Isolation from Neutropenia and feeling lethargic have kept me from participating in most aspects of my normal life.”
- “Following a stem cell transplant, left with a compromised immune system.”
- “I limit my exposure to large groups by avoiding hockey games, symphony etc, so I feel isolated”
- “Being on leave and then returning to life, work after was the hardest thing for me”
- “my neuropathy in feet and hands, impacts current day to day life, ie drop items and trip/lose balance occasionally. I do not feel as cognitively bright as I was in the past.”

Patients were further asked to comment on which side effects were the most difficult to tolerate. Responses are as follows:

- “Severe reduction in white blood cells after every treatment, necessitating infections to boost the production of white blood cells, these infections would cause me to black out of I try to get up from a crouching position. General fatigue from chemo in 2nd week following each treatment”
- “nausea and vomiting”
- “Mouth sores, fevers, nausea, yeast infections, infections, hospitalizations, low iron, low white blood count, muscle loss, inability to walk or breathe properly, chest heaviness, pain and swelling, etc”
- “Bone pain & effects of Prednisone”

- “Neuropathy, Febrile neutropenia, Steroid induced diabetes”
- “Fatigue, hair loss”
- “Lack of energy”

4. Experiences With Currently Available Treatments

Patients who completed the Lymphoma Canada survey were asked how many lines of treatment they received to treat their Diffuse Large B-cell lymphoma. The majority of 11 patients indicated they received 1 (36%), 2 (36%), or 3 or more (27%) lines of treatment, see Table 6. Overall, majority of patients relapsed and needed treatment past the frontline setting (63%).

Table 6: Number of lines of therapy survey respondents received

Respondents	1	2	3+	Skipped	Total
Patients with Diffuse Large B-cell lymphoma	4	4	3	31	41

In the front-line setting, 10 patients received R-CHOP, and one received RCHOP and REPOCH. In second line, 2 patients received R-GDP, 2 received salvage therapy + autologous stem cell transplant, 3 received radiation, and 4 were on a clinical trial. In the third line of treatment, 3 patients received CAR T-cell therapy, 1 received Pola-BR, 2 received Glofitamab and 5 were on a clinical trial.

These patients were asked: “How satisfied were you with the number of treatment options available to you for your lymphoma?”. 54% of patients indicated they were very satisfied with their frontline treatment options, while only 20% of survey respondents gave the same rating in the relapsed/refractory setting. This indicates patients are significantly less pleased with their treatment options in second and third-line+ settings.

11 patients provided information about their ability to access their DLBCL treatment. 8 patients found it not difficult at all or not very difficult to access treatment, while 3 patients had some difficulty. Here are some comments from patients as to why:

- “Had to travel and stay overnight for treatment, which was difficult”
- “Finances. Not covered by Ohip.”

The most common financial implications reported for treatment for DLBCL was absence from work (60%), drug costs (30%), supplementary drug costs for side effects (30%), and travelling costs (30%).

Overall, positive feedback regarding current care was primarily regarding the exceptional support and expertise of their treating healthcare team, as follows:

- “ Great oncology team is what kept me going.”

- "The people involved have been my most positive experience"
- "Even though my experience was during the pandemic, there was never a delay in test, diagnosis or treatment. I have the good fortune of having an excellent GP and oncologist. They saved my life."

5. Improved Outcomes

DLBCL patients which completed the Lymphoma Canada survey (11) were asked how important it was for a new drug to control/treat their Diffuse Large B-cell lymphoma. Patients indicated factors such as longer disease remission (100%), longer survival (100%), control disease symptoms (90%), normalize blood counts (90%), and improved quality of life to perform daily activities (90%), were very important to them. 7 of these patients indicated they would be willing to tolerate side effects to access new treatment and 6 patients indicated choice is important to them in deciding to take a drug based on known side effects and expected outcomes of treatment.

6. Experience With Drug Under Review

From survey responses, 2 patients indicated that they were treated with Glofitamab in combination with gemcitabine and oxaliplatin. Both patients were male and from the US, and 1 patient was treated less than 6 months ago, while the other was treated 1-2 years ago. One of these patients accessed the drug through private insurance and the other was through medicare or public care. Upon receiving this therapy, both patients are still currently in remission. Side effects experienced included decreased appetite (2), nausea/vomiting (2), fatigue (2), cytokine release syndrome (1), fever (1), neutropenia (1), and low platelet count (1). Both DLBCL patients experienced financial impacts as a result of absence from work and travel. Despite these challenges, the patients rated their overall experience with Glofitamab in combination with gemcitabine and oxaliplatin as good and satisfactory, and both would recommend the therapy to other DLBCL patients. No other responses or comments were provided by these patients.

7. Companion Diagnostic Test

N/A

8. Anything Else?

Lymphoma Canada is an advocate for lymphoma patients and their caregivers to have access to novel lymphoma therapies. An increased number of available treatment options gives patients more choice to decide the therapy that is right for their personal goals, with their medical care team. A large majority of patients relapse from LBCL after first treatment, indicating there is a need for more and better therapeutic options for this subset of patients.

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
Roche			X	
Gilead				X
Incyte			X	
Novartis			X	
BMS				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: Gurjot Basra
Position: Manager of Patient Programs, Research, and Advocacy -
Patient Group: Lymphoma Canada
Date: March 24, 2025

CADTH

Clinician Group Input Template
CADTH Reimbursement Review

Clinician Group Input

CADTH Project Number: PC0406-000
Generic Drug Name (Brand Name): Glofitamab (Columvi)
Indication: Columvi (glofitamab for injection) in combination with gemcitabine and oxaliplatin for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are not candidates for autologous stem cell transplant (ASCT).
Name of Clinician Group: Lymphoma Canada
Author of Submission: Dr. Robert Puckrin, Dr. Carolyn Owen, Dr. Pamela Skrabek, Dr. Mona Shafey

1. About Your Clinician Group

Lymphoma Canada is a national organization dedicated to research, education, and raising awareness for the benefit of patients with lymphoma across Canada. (Home - Lymphoma Canada)

2. Information Gathering

We conducted a literature search of PubMed for published clinical trials of glofitamab in combination with GemOx as well as other treatments for relapsed/refractory diffuse large B-cell lymphoma (DLBCL).

3. Current Treatments and Treatment Goals

Diffuse large B-cell lymphomas (DLBCL) are a closely related group of aggressive lymphoid malignancies which account for approximately 30% of all non-Hodgkin lymphomas (1). First line treatment for most eligible patients is R-CHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone) chemoimmunotherapy, which may cure up to 60-70% of patients. However, 30-40% of patients will relapse or be refractory to R-CHOP. The current standard of care for younger, medically fit patients who are refractory to or relapse within 12 months of R-CHOP is second-line chimeric antigen receptor (CAR) T-cell therapy, which has demonstrated significant improvements in progression-free survival (PFS) and overall survival (OS) compared to the previous standard of care (2-5). Younger, medically fit patients relapsing more than 12 months after R-CHOP are treated with second-line chemoimmunotherapy and autologous stem cell transplantation (ASCT) (6, 7), while those not responding to second-line chemoimmunotherapy or who relapse after ASCT may go on to receive third-line CAR-T cell therapy (8-10). These intensive therapies are given with the goals of curing lymphoma, prolonging survival, and improving quality of life.

However, many patients with relapsed/refractory DLBCL are ineligible for curative-intent but intensive therapies such as ASCT or CAR-T cell therapy due to older age, comorbidities, rapidly progressive or chemorefractory disease, inability to mobilize stem cells or manufacture CAR-T cells, funding restrictions, and/or social and geographic barriers to transplant and cellular therapy centres. Additionally, many patients experience disease relapse after ASCT or CAR-T cell therapy and require further treatment for their life-threatening lymphoma. In these scenarios, patients may receive palliative-intent second-line chemoimmunotherapy regimens such as R-GemOx or polatuzumab/bendamustine-rituximab (pola-BR) (11, 12) and/or novel third-line regimens such as bispecific antibody monotherapy with glofitamab or epcoritamab (13, 14). These regimens are typically not curative in most patients with relapsed/refractory DLBCL but may help to reduce symptoms from lymphoma, prolong survival, and promote 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.

Many patients with relapsed/refractory DLBCL are unable to receive curative-intent therapies such as ASCT or second-line CAR-T cell therapy due to older age or comorbidities which render them unlikely to tolerate the potentially severe toxicities of these intensive treatments (15). In addition, the funding restrictions and logistical challenges of ASCT and CAR-T cell therapy make these options unfeasible for many patients who have rapidly progressive or chemorefractory disease, are unable to mobilize stems cells or manufacture CAR-T cells, do not wish to undergo a prolonged hospitalization, or face social and/or geographic barriers to specialized transplant and cellular therapy centres. These patients are instead typically treated with palliative-intent second-line chemoimmunotherapy regimens such as R-GemOx or pola-BR. Although these regimens may achieve a temporary response, most patients will eventually relapse and require additional cancer treatment or die from their disease. As a result, the median overall survival following R-GemOx or pola-BR is only in the range of 9-12 months (11, 12, 16, 17), highlighting the unmet need for more effective therapies. Bispecific antibodies such as glofitamab or epcoritamab monotherapy are now available in the third-line setting in Canada, but despite their promising efficacy, the majority of patients will either not respond or develop resistance to bispecific antibodies and have no other effective treatments available. In addition, some regimens such as pola-BR may cause profound depletion of T-cells that may negatively impact future immunotherapy treatments such as CAR-T cell therapy or bispecific antibodies (18). For these reasons, there is an unmet need for more effective and well-tolerated treatments for relapsed/refractory DLBCL, particularly among patients who are ineligible for, unable to receive, or have already received intensive treatments such as ASCT or CAR-T cell therapy.

5. Place in Therapy

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

Glofitamab is a CD20xCD3 bispecific antibody which can effectively treat lymphoma even when other therapies have failed by redirecting a patient's T-cells to target the malignant B-cells. In the phase III STARGLO trial of 274 patients with relapsed/refractory DLBCL who received ≥1 prior line of therapy and were ineligible for intensive therapies such as ASCT, glofitamab in combination with GemOx chemotherapy resulted in a significant improvement in complete response (CR) rate (59% versus 25%), progression-free survival (median 14 versus 4 months), and overall survival (median 26 versus 13 months) compared to standard R-GemOx chemoimmunotherapy. This represents the first phase III trial to demonstrate an overall survival advantage among patients with relapsed/refractory DLBCL who are ineligible for ASCT. Importantly, the 2-year PFS rate >40% suggests that glofitamab-GemOx may have curative potential in a significant proportion of patients, thereby fulfilling a previously unmet need for this high-risk population.

For patients who are ineligible for or unable to receive intensive therapies such as ASCT or CAR-T cell therapy, glofitamab-GemOx has a favorable safety profile with low rates of high-grade cytokine release syndrome (CRS) (2%) or neurotoxicity (1%), making it a suitable treatment for many older patients or those with comorbidities who may not tolerate the more severe toxicities of ASCT or CAR-T cell therapy. Unlike CAR-T cell products which have an approximately 4- to 8-week manufacturing period and risk of manufacturing failure, glofitamab-GemOx is quickly available 'off the shelf' which makes it better suited for patients with rapidly progressive or symptomatic disease who need urgent treatment. In addition, glofitamab-GemOx is logistically more convenient to administer than ASCT or CAR-T cell therapy as it does not require apheresis, bridging therapy, or central line insertion. Glofitamab-GemOx also has the potential to be given in the outpatient and community hospital settings, making it appealing from a quality of life perspective and more accessible to patients across Canada who may not live close by a specialized cellular therapy centre where ASCT or CAR-T cells are administered. Glofitamab also has a fixed duration of treatment consisting of 12 cycles administered over an 8-month period, which has the potential to reduce toxicity and healthcare costs while improving quality of life and time-off-treatment compared to some other treatment options for relapsed/refractory DLBCL that are given indefinitely.

Once funded, glofitamab-GemOx would be expected to change the treatment landscape of relapsed/refractory DLBCL in Canada by replacing R-GemOx or pola-BR as the new preferred second-line regimen for many patients who are ineligible for or do not wish to to receive intensive therapies such as ASCT or CAR-T cell therapy. Glofitamab-GemOx would also be an appropriate third-line treatment option for certain patients with relapsed/refractory DLBCL. Given the absence of direct clinical trial comparisons between

third-line glofitamab-GemOx and other options such as third-line CAR-T cell therapy or glofitamab or epcoritamab monotherapy, the choice between third-line regimens would likely depend on patients' age, comorbidities, values and preferences, treatment history, prior response to chemotherapy, tumor burden, cytopenias, etc.

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 would be best suited for glofitamab-GemOx if they have relapsed/refractory DLBCL after ≥1 line of therapy and are ineligible for, unable to receive, or decline intensive therapies such as ASCT. Of note, these patients are also typically considered ineligible for second-line CAR-T cell therapy in Canada due to funding restrictions limiting this treatment to patients who are eligible for ASCT. Patients receiving glofitamab-GemOx should have an adequate performance status, hematopoietic reserve, and organ function to be expected to tolerate both the glofitamab and GemOx components of treatment.

Patients would not be suitable candidates for glofitamab-GemOx if they are eligible for and able to receive intensive therapies such as ASCT, because glofitamab-GemOx has not yet been studied in this population. Glofitamab-GemOx would also not be recommended for patients whose disease is already refractory to a CD20xCD3 bispecific antibody or to GemOx chemotherapy. In addition, some patients may not be appropriate candidates for this regimen due to poor performance status, inadequate organ function, active uncontrolled infections, or active central nervous system (CNS) lymphoma.

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 with PET or CT (depending on local diagnostic imaging resources) is typically performed after cycle 4 of glofitamab-GemOx. Most patients who achieve a response to glofitamab-GemOx do so by the first response assessment. Repeat imaging may be considered after cycle 8 and at the end of treatment depending on the initial depth of response and physician discretion.

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

As per the study protocol, treatment with glofitamab should be continued for a total duration of twelve 21-day cycles and treatment with GemOx should be continued for up to eight 21-day cycles in responding patients, although either component of the regimen may be discontinued earlier due to disease progression or unacceptable adverse events. Of note, glofitamab-GemOx is generally well tolerated by most patients and <7% of patients discontinued glofitamab due to drug-related adverse events in the STARGO trial.

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

Glofitamab should be administered by a Hematologist or Oncologist with familiarity managing the potential adverse events of bispecific antibodies (including CRS, neurotoxicity, cytopenias, infections, hypogammaglobulinemia, tumor lysis syndrome, and tumor flare) and cytotoxic chemotherapy (including cytopenias, infections, and gastrointestinal and other organ toxicities). A brief period of inpatient monitoring for CRS may be considered after C1D8 treatment during the glofitamab dose-ramp up phase, and patients should receive the first 3 doses of glofitamab at a facility with access to tocilizumab and intensive care unit support for rare occurrences of high-grade CRS. Over the past several years, a growing number of treatment centers across Canada have developed expertise in the administration and management of adverse effects of bispecific antibodies. It is rare for CRS to occur after the third dose of glofitamab, and subsequent doses can usually be given as an outpatient or in the community hospital setting. In general, bispecific antibodies such as glofitamab are associated with significantly lower rates of severe CRS and neurotoxicity than many CAR-T cell products, particularly with obinutuzumab/corticosteroid pre-medication and ramp-up dosing. Glofitamab-GemOx is thus an appropriate regimen to be given completely or partially in the community hospital setting, which would improve access to treatment and convenience for patients across Canada.

6. Additional Information

We acknowledge the inclusion of DLBCL NOS under the requested reimbursement indication. However, other histologic subtypes of DLBCL are generally treated similarly as DLBCL NOS and are likely to benefit from glofitamab-GemOx as well. Studies confirm that bispecific antibodies are effective against a wide range of histologic subtypes of DLBCL (13, 14), and these patients should not be excluded from glofitamab-GemOx given the significant improvements in overall survival achieved by this therapy.

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.

   No

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: Robert Puckrin
Position: Hematologist, Arthur Child Cancer Centre and University of Calgary
Date: 16-Feb-2025

☒ **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
Abbvie	X			
Astrazeneca	X			
Beigene	X			

Eli Lilly	X			
Incyte	X			
Janssen	X			
Kite	X			
Roche	X			
Seagen	X			

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

Declaration for Clinician 2

Name: <Carolyn Owen>
Position: <Associate Professor University of Calgary and Alberta Provincial Hematology Tumour Group Lead>
Date: <24-02-2025>

☒ 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**
Roche	X			
Abbvie		X		
Beigene		X		
Astrazeneca		X		
Merck	X			
Incyte	X			
Janssen	X			

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

Declaration for Clinician 3

Name: Dr Pamela Skrabek
Position: Hematologist, CancerCare Manitoba, Associate Professor
Date: 21-02-2025

☒ 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
Hoffmann-La Roche Ltd.	X			
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: Mona Shafey
Position: Clinical Associate Professor, Depts Medicine & Oncology, University of Calgary
Date: 25-Feb-2025

☒ 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 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**
Kite/Gilead		X		
BMS	X			
Roche	X			
Incyte	X			
AbbVie	X			

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

REFERENCES

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CADTH

CADTH Reimbursement Review

Clinician Group Input

CADTH Project Number: PC0406-000
Generic Drug Name (Brand Name): Glofitamab (Columvi)
Indication:
Manufacturer Requested Reimbursement Criteria[1]:
Columvi (glofitamab for injection) in combination with gemcitabine and oxaliplatin for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are not candidates for autologous stem cell transplant (ASCT).
Name of Clinician Group: Ontario Health (Cancer Care Ontario) Hematology Cancer Drug Advisory Committee
Author of Submission: Dr. Tom Kouroukis and members of the OH (CCO) Hem DAC

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.

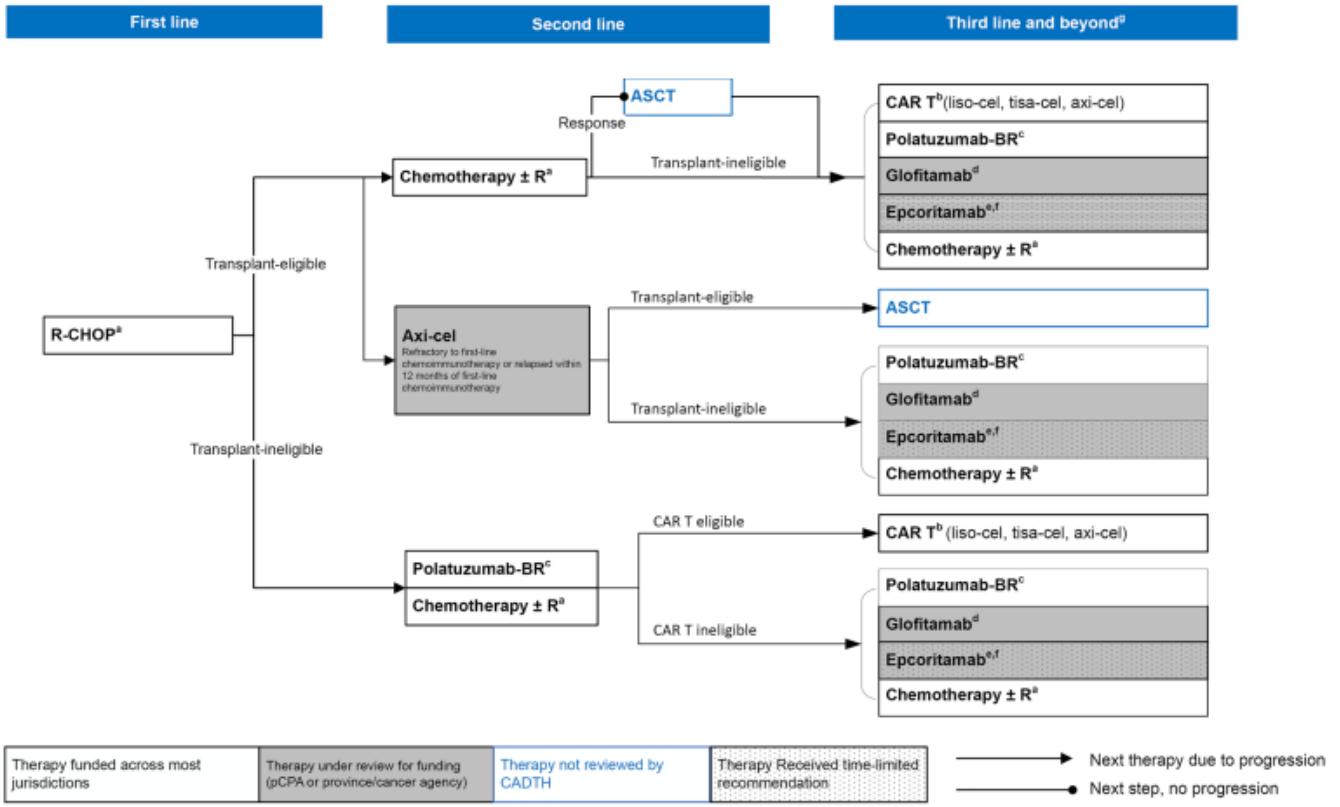
2. Information Gathering

Information was gathered via teleconference meeting.

3. Current Treatments and Treatment Goals

Provisional Funding Algorithm

Figure 1: Provisional Funding Algorithm Diagram for Large B-Cell Lymphoma



ASCT = autologous stem cell transplant; axi-cel = axicabtagene ciloleucel; BR = bendamustine and rituximab; CAR = chimeric antigen receptor; liso-cel = lisocabtagene maraleucel; pCPA = pan-Canadian Pharmaceutical alliance; R = rituximab; R-CHOP = rituximab in combination with cyclophosphamide, doxorubicin, vincristine, and prednisone; tisa-cel = tisagenlecleucel.

[a] Alternative R-chemotherapy regimens available.

[b] If not received previously, polatuzumab-BR can be offered for bridging to CAR T-cell therapy.

[c] Polatuzumab-BR is only funded for patients who are ineligible for ASCT and have received at least 1 prior therapy or have relapsed or progressed after prior ASCT. Polatuzumab-BR is only funded in patients who have not previously received polatuzumab-BR.

[d] For patients who have received 2 or more lines of systemic therapy and are ineligible to receive or cannot receive CAR T-cell therapy or have previously received CAR T-cell therapy.

[e] For patients who have received 2 or more lines of systemic therapy and who have previously received or are unable to receive CAR T-cell therapy.

[f] Epcoritamab received a time-limited recommendation in favour of reimbursement contingent on a future reassessment of additional evidence that addresses uncertainty.

[g] Third-line options may be used in the fourth line, provided that therapy has not been used previously.

Re: Figure 1 – CDA Provisional Funding Algorithm for large B cell lymphoma - Available treatment for patients with relapsed/refractory DLBCL who are not candidates for ASCT are polatuzumab-BR or other chemotherapy combinations.

Treatment goals: Improved disease response, progression-free survival (PFS) and overall survival (OS), quality of life (QoL), and disease-related symptoms.

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.

Currently available second-line options are not curative. Response rates, PFS, and OS are poor with available therapies. Bendamustine (as part of pola-BR) may make third-line CAR T challenging.

5. Place in Therapy

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

Glofitamab-Gem-Ox can be an option instead of pola-BR and other R-chemotherapy options.

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?

Best suitable – as per clinical trial – patients not eligible for high dose chemotherapy related to comorbidities. Patients who may be eligible for CAR T second line should proceed along that route.

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?

Standard lymphoma response measures.

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

Disease progression or significant toxicities.

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]?

Glofitamab ramp up often requires in-patient monitoring or administration.

6. Additional Information

If a patient is not refractory to second-line glofitamab, the patient should be eligible for retreatment with bispecifics at the later line setting.

According to the study, transplant-ineligibility was based on age (>70), comorbidities, or patient's choice or local practice. Many centres in Ontario do not have a strict age cut-off limit for transplant. Therefore, transplant ineligibility should be based on clinical assessment.

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 PDRP provided 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 <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. Tom Kouroukis
Position: Lead, Ontario Health (Cancer Care Ontario) Hematology Cancer Drug Advisory Committee
Date: 27-02-2025

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

Table 1: Conflict of Interest Declaration for Clinician 1

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

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

Declaration for Clinician 2

Name: Dr. Christopher Cipkar
Position: Member, OH-CCO Hem DAC
Date: 27-02-2025

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

Table 2: Conflict of Interest Declaration for Clinician 2

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

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

Declaration for Clinician 3

Name: Rami El-Sharkaway
Position: Member, OH-CCO Hem DAC
Date: 27-02-2025

☒ 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
Roche	X			
Add company name				
Add or remove rows as required				

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

Declaration for Clinician 4

Name: Dr. Jordan Herst
Position: Member, OH-CCO Hem DAC
Date: 27-02-2025

☒ 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: Dr. Selay Lam
Position: Member, OH-CCO Hem DAC
Date: 27-02-2025

☒ 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**
Roche		X		
Add company name				
Add or remove rows as required				

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

Declaration for Clinician 6

Name: Dr. Lee Mozessohn
Position: Member, OH-CCO Hem DAC
Date: 27-02-2025

☒ 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 6

	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 7

Name: Dr. Guillaume Richard-Carpentier
Position: Member, OH-CCO Hem DAC
Date: 27-02-2025

☒ 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 7

	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.