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

CDA-AMC REIMBURSEMENT REVIEW

Patient, Clinician and Industry Input

dabrafenib-trametinib

(non-sponsored review)

Indication: in pediatric and young adult patients for 1st line or greater therapy in low grade gliomas with residual disease and with known BRAF V600 mutations.

Dec 6, 2024

This document compiles the input submitted by patient groups, clinician groups, and industry 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 Pharmaceuticals@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.

By filing with CDA-AMC, the submitting organization or individual agrees to the full disclosure of the information. CDA-AMC does not edit the content of the submissions received.

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

Patient Input Template for CADTH Reimbursement Reviews

Name of Drug: dabrafenib-trametinib
Indication: pediatric Low Grade Glioma
Name of Patient Group: Ac2orn (Advocacy for Canadian Childhood Oncology Research Network)
Author of Submission: Keith McIntosh

1. About Your Patient Group

Ac2orn was founded in 2014 to advocate for translational research and effective treatments to support the goal of curing childhood, adolescent, and young adult (CAYA) cancers. It is a grass-roots, volunteer organization made up of parents from across Canada, who have children with different types of cancer, and the desire to help improve pediatric oncology research and outcomes. Ac2orn works to achieve its mission by connecting with CAYA health advocacy groups across Canada; identifying and addressing barriers that exist in accessing treatments and cancer clinical trials, and educating policy makers, industry, and others about the issues facing the CAYA cancer community.

Ac2orn has a broad network across Canada and connected with parents, and childhood cancer organizations across Canada, as well clinicians in the C17 network of pediatric hematology, oncology, and stem cell transplant programs.

www.ac2orn.com

2. Information Gathering

We used several methods to contact families affected by pediatric Low Grade Gliomas, including those who had experience with dabrafenib and/or trametinib.

- We shared details of the request and purpose with pediatric neuro-oncologists across Canada, asking them to share with families they know are affected, and had experience with the drugs.
- We shared the request via relevant closed social media groups for families affected by childhood cancer, including some specific to CNS tumours.
- We contacted a national charity focused on CNS malignancies, requesting support for preparing the submission, and collecting data.

Until the very end of the public comment period, we were unable to identify any families willing and able to participate in this information gathering exercise, despite the fact that this represents a relatively large patient population. The number of patients who have had access to the drugs under review is much, much, smaller.

On December 6 we were contacted by one parent, and on Dec 7th we were contacted by 2 other parents. Unfortunately, we were unable to arrange a conversation with any of these families over the weekend between December 6 and 9, 2024.

3. Disease Experience

When a child or adolescent is diagnosed with cancer it has profound long-term physical, emotional, and financial impacts on the young person and their family.

A brain tumor diagnosis sometimes occurs incidentally, but it often follows a circuitous path of a parent inquiring, investigating, and asking for Health Care Provider support to understand a list of consistent, but vague, signs and symptoms (Headache, Dizziness, Sleepiness, Balance Problems, Nausea and Vomiting, Vision/Hearing/Speech Changes).

After discovery of the tumour, everything accelerates and becomes urgent. If you aren't already at or proximate to a specialty tertiary children's hospital, you are expedited to the children's hospital for imaging, and further investigation.

We note the findings of the Pediatric Low-Grade Glioma Multi-stakeholder Meeting[1] from the patient community representatives. Key messages from 9 people from the patient community were grouped into the following themes:

Access to Treatment

- Accessing treatment is time-intensive for parents and their children, and adds to the already heavy burden of caring for a sick child.
- There is a perception of a lack of novel and potentially effective treatments in Canada.
- There is a reliance on communication with other families with lived experience, through virtual platforms, to guide them in their search for treatment options and what to expect from the care process.
- At completion of clinical trials or treatment courses, families wait for the next steps in the care pathway.

[1] https://www.cda-amc.ca/sites/default/files/RWE/pdf/multi-stakeholder_dialogue_optimizing-the_use-of_real-world_evidence_for_decision-making_for_pediatric_low-grade_glioma_in%20_canada.pdf

Variation in Care

- Provinces and territories may have differing approaches to treatment plans.
- Clinicians operating in the same institution may have differing approaches to providing care.
- Access to specialist physicians and resources can vary based on geographical location.
- There is a perception of a lack of coordination between hospitals across Canada and with care providers in the US and elsewhere.
- The care pathway can make it difficult for children to maintain their personhood.
    - Seeing a consistent set of specialists familiar with the child as an individual and integrated access to psychosocial care were perceived as beneficial.

Financial Burden of Care

- Drugs for pediatric oncology and other rare diseases can often be associated with high costs and problems with access, especially when they are not listed on the public formulary and prescribed “off-label” (e.g., out-of-pocket treatment costs, access issues).
- Out-of-pocket costs can include:
    - medical tests and procedures
    - medical supply and equipment costs for at-home care
    - complementary alternative medicines (e.g., vitamins, supplements)
    - psychosocial support, childcare, and other non-medical supports
    - cost of travelling within or outside of Canada to receive care (e.g., lodging, other accommodations, and/or transportation costs such as gas, parking fees, and public transit).
- Some have experienced misalignment in the language and requirements communicated between physicians and insurance companies, and this disconnect often falls on the family to manage.

Other Challenges

- Orally administered versus IV therapies may be preferred because they can be administered outside of treatment centres, which:
    - allows children to miss fewer days at school and with friends
    - reduces the burden on caregivers in terms of travel time
    - reduces expenses and potential missed days at work.
- There are barriers associated with the transition from care in pediatric centres to adolescent/adult centres.

Indicators and Outcomes

- To access certain targeted treatments, confirming a patient’s molecular tumour status is frequently required, and there are also uncertainties surrounding the complex classification of pLGG and associated cancers, which can add further complexity to accessing treatments indicated for specific tumour types and patient populations.

- There should be an increased focus on outcomes and indicators related to the mental health of patients and their families, as well as children's social development while living with the disease.
- Indicators such as days a child misses from school, emotional burden, academic performance, and the ability to develop and maintain personal relationships should be considered.
- Given the relatively recent availability of targeted therapies and their use in pediatric populations, a more thorough, comprehensive, and long-term follow-up of patients should be considered, including acknowledgement of the following:
    - There are unknown effects of targeted treatments in terms of safety, and effects on other factors, such as a child's perception of self, their body image, fertility, and the ability to engage in social relationships.
    - Patients can age out of pediatric indications and may no longer have access to the same treatment options, support services, or care providers as they grow with their disease.
- • Financial burdens are experienced by caregivers and families, including loss of income and missed time from work; travel and accommodation for accessing treatment options; the cost of accessing high-cost therapies, home care and other supports; and the need for resources for emotional and psychosocial support.

High survival rates in pediatric low-grade gliomas (pLGG) can overshadow significant long-term toxicities and functional impact on patients. This[2] paper challenges the idea that pLGG are "benign" and found that: 57% of survivors experienced cognitive deficits. Young children (50%) and adolescents (42%) had low cognitive functioning scores, correlating with poor academic ($p < 0.01$) and standardised school educational tests' performance. 42% of mainstream school attendees required learning support; 33% examination assistance; 50% completed secondary education and 22% a tertiary degree, but had attention (young child and adolescent), and memory (young adult) issues. 65.9% of survivors had at least one neurological concern, highest in adolescents (70%). Language deficits (42.9%), pain, fatigue, and hearing loss (28.6 %) in young children; and vision/sleep difficulties (35%); fatigue (30%) and mobility (25%) in adolescents were reported.

There is a clear need for better and less toxic treatments.

[2] Nagabushan S, Hamayun M, Fardell JE, Donoghoe M, Bland E, Bye A, Jacobson E, Manoharan N, Ziegler DS, McLoone JK, Johnson AM, Cohn RJ. LGG-11. COGNITIVE, ACADEMIC, AND QUALITY OF LIFE OUTCOMES IN SURVIVORS OF PEDIATRIC LOW-GRADE GLIOMA: CHALLENGING THE 'BENIGN TUMOR' PERCEPTION. Neuro Oncol. 2023 Jun 12;25(Suppl 1):i57–8. doi: 10.1093/neuonc/noad073.221. PMCID: PMC10260123.

4. Experiences With Currently Available Treatments

The short-term mortality risk is low for pLGG; however it is associated with devastating morbidities that can include neurological impairments including seizures, behavioral/cognition disorders, and ocular/visual (including blindness).

Surgery, radiation and existing chemotherapies all have important toxicities.

We were unable to speak with any family who had experience with pLGG for this review.

5. Improved Outcomes

We note the outcomes identified in the Pediatric Low-Grade Glioma Multi-stakeholder Meeting.

- The short-term mortality risk is low for pLGG; the morbidities, however, can be devastating (e.g., blindness) and need to be captured.
- Radiation-free survival and delaying or avoiding the use of increasingly toxic chemotherapy agents are important outcomes to consider; pLGG patients have a long survival, so deferring (or avoiding) these interventions can help decrease or prevent long-term sequalae.
- Secondary neoplasms: If a patient receives a chemotherapy agent or radiation therapy, there is the potential to develop cancer in a different location.

6. Experience With Drug Under Review

We were unable to speak with any family who had experience with the drugs under review.

We note, however, that of all the drugs identified as standard of practice at the Pediatric Low-Grade Glioma Multi-stakeholder Meeting, only Trametinib has an approved label indication for this use. Patients and families have identified the absence of approved therapies as a frustration and an unmet need.

We submit that there should be a bias toward reimbursing the very small number of drugs that achieve a regulatory approval for use in a pediatric cancer – as a demonstration of the strength of clinical evidence. If Canada's health system can't reimburse drugs that achieve a regulatory approval for childhood cancer, there seems little hope for modern therapies that demonstrate strong evidence of clinical benefit but do not achieve an approved indication for childhood use.

7. Companion Diagnostic Test

8. Anything Else?

As noted above, we are submitting this feedback late as we did not have any direct feedback, but identified several families with experience with the drug at the very end of the comment period and hoped to be able to conduct interviews between Friday (December 6) and Monday (December 9). We were not successful in arranging these conversations.

If we can speak with these families, we plan to supplement these comments with the information we can collect.

These information-gathering exercises are not easy. To collect a survey response, it requires a parent – usually a mother, often bereaved – to relive the memories of days or months spent in hospital with a very sick child receiving treatments. That is a deeply personal and emotional request, and in survey form, they are alone. When the information is collected via interviews, the respondent is not alone, but the emotional burden is the same or may be greater. It is often easier to type these painful memories than it is to say it out loud. As parents who have experienced childhood cancer, these exercises are also difficult for Ac2orn members.

A further complication affecting information gathering is that the process includes an early request to clinicians across the country to reach out to families and connect them with a designated member of Ac2orn. This process relies on exceptionally busy individuals, often reaching out to bereaved families and even times connecting with families who may have conflicted relationships with the clinicians and/or hospitals. We have received feedback from clinicians that they are aware of patient(s) who might have relevant information, but the clinician/family relationship meant that they were not able to make the necessary connections.

It is important that the Committee doesn't take the absence of specific patient input on the drugs under review as absence of interest, or absence patient need.

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

N/A

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: Keith McIntosh
Position:Chair
Patient Group: Ac2orn (Advocacy for Canadian Childhood Oncology Research Network)
Date: December 9, 2024

CADTH

CADTH Reimbursement Review

Clinician Group Input

CADTH Project Number: PX0375-000
Generic Drug Name (Brand Name): dabrafenib-trametinib
Indication: In pediatric and young adult patients for 1st line or greater therapy in low grade gliomas with residual disease and with known BRAF V600 mutations.
Name of Clinician Group: Pediatric Oncology Group of Ontario
Author of Submission: Dr. Paul Gibson

1. About Your Clinician Group

POGO is a collaboration of Ontario's 5 specialized childhood cancer centres and the official advisor to the Ministry of Health and Long-Term Care on pediatric cancer care and control. This submission represents a collaboration of pediatric cancer clinicians from across the province with membership informed by POGO's Therapeutic and Technology Advisory Committee (TAC). For more information on POGO, please visit www.pogo.ca

2. Information Gathering

This submission was prepared in a consultative manner. Dr. Gibson discussed the indication with members of the submission panel and sought input from the POGO's Technology and Therapeutic Advisory Committee (TAC). Dr. Gibson subsequently drafted the initial response and TAC members or their delegates contributing to the submission reviewed and edited the draft that has led to this final submission. Given the nature of the patient population (pediatric and AYA), colleagues treating young adults were also invited to provide commentary and endorsement.

3. Current Treatments and Treatment Goals

Low grade gliomas (LGGs) are a common pediatric brain tumour with a wide variety of clinical presentations and course. Most tumours are diagnosed via tissue biopsy which may or may not include surgical resection or debulking, depending on location. The exception to this is Optic Pathway Gliomas, which are typically diagnosed using history (including a history of neurofibromatosis type 1), clinical examination (via ophthalmology) and imaging (MRI). Low Grade Gliomas have a low metastatic potential and in young patients have a lower potential for transformation to high grade gliomas.

Traditionally, therapy for LGGs in young patients has included 3 potential modalities: surgery, cytotoxic chemotherapy and radiation therapy. While total resection and/or large tumour debulking is preferred, when possible, this is uncommon due to unacceptable morbidity. Similarly, while radiation therapy may halt tumour progression, there are serious late effects, including neurocognitive and developmental factors in addition to the risk of a second malignancy in these young patients that make it undesirable in early lines of therapy. Therefore, systemic therapy with the goal of shrinking or at least stabilizing tumour mass is often the 'front line' therapy.

Traditionally, the LGG systemic therapy has used the combination of vincristine and carboplatin or vinblastine monotherapy. Both these approaches, while reasonably effective, carry significant challenges. In most patients, they require the placement of a central line, particularly given that vincristine and vinblastine are vesicants and delivered weekly, making the risk of extravasation significant and requiring most patients to have central venous access. Furthermore, patients and families are required to attend a clinic weekly for infusions and are at risk for infectious complications for months to years. Despite all these challenges, a significant portion of patients will experience tumour progression and be forced to face latter line cytotoxic therapy or eventually radiation therapy.

The recognition of BRAF aberrations and subsequent availability of BRAF targeting agents has changed the treatment paradigm for LGG therapy. BRAF pathway targeting has provided a distinctly new, oral therapy that delivers significant anti-tumour activity without the need for central lines and weekly clinic attendance.

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.

As outlined above, traditional cytotoxic chemotherapy presents a significant burden on patients and families. Weekly infusion visits coupled with unplanned assessments due to infectious risks created by cytotoxic therapy. The tumour response rates to these traditional chemotherapeutic agents is low. These young patients attend clinic visits at the expense of missing school and/or work at a time when their educational and vocational development is crucial. There is a clear need for effective therapies that lower the burden of treatment (central lines, weekly blood work and infusions).

In adults, LGG that harbor a BRAF mutation have classically been treated with radiation therapy at the time of progression. Understanding the potential long-term neurocognitive effect of radiation, targeted therapies represent a new option to delay or arrest further progression.

5. Place in Therapy

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

The combination of dabrafenib and trametinib (dab-tram) has shown clear superiority compared to traditional cytotoxic chemotherapy (vincristine and carboplatin) when used as first line systemic therapy in patients with tumours harboring BRAF V600 mutations. Dab-tram produced more responses with greater durability and with substantially less adverse events. With these results in mind, there is strong evidence that patients with BRAF V600 mutated LGGs should be offered this therapy in frontline. It may be however, that for a variety of reasons, including the ability to take oral medications, patients and families may opt to try traditional cytotoxic therapy (vincristine and carboplatin or single agent vinblastine) prior to initiating dab-tram. Should these patients not achieve an acceptable response, dab-tram should be available to them in second line.

Dab-tram represents a new paradigm in treatment of LGGs in young people. In the past, radiation therapy and cytotoxic chemotherapy were applied without clear reflection of the underlying biology. Conversely, dab-tram represents targeted agents based on known biologic changes in tumours.

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?

The decision to start systemic therapy in LGGs is multifactorial. Clinicians consider the size and location of the mass, the patients current symptom burden and also patient and family preferences. BRAF assessment is now routine in the diagnosis of LGGs in Ontario. Patients with BRAF V600 mutated tumours requiring systemic therapy should be strongly considered for dab-tram therapy. The best suited patients for dab-tram are those with known BRAF V600 who are able to tolerate enteral medications and thought to be likely to comply well to daily home medication administration. Conversely, patients who are unable to take oral medications or unable to ensure their regular compliance may be better suited for the more structured approach of weekly intravenous cytotoxic therapy.

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?

There are two main factors in determining response. The first is imaging. Patients should receive baseline MRIs and be reevaluated at minimum 3 months after initiating therapy or sooner if clinical concern dictates. Ongoing monitoring every 3 months can often reveal response to targeted therapy (sometimes in the form of tumour shrinkage) over the course of several months. In some cases, complete radiological response may be achieved. Secondly, the patient's neurologic status, measured both by patient reported symptoms and neurologic examination. Standard tools capturing both clinician-reported neurological examinations (such as the Neurological Assessment in Neuro-Oncology scale) and patient-reported outcomes exist to help aid physicians in this assessment. While the ultimate goal is tumour shrinkage and improved neurologic status, for many patients, radiologic stability and the absence of neurologic deterioration may be considered a successful therapy response.

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

Patients with clear radiographic or clinical progression over time should be considered for alternative therapies to dab-tram. Multidisciplinary discussions around complex cases should be encouraged. In addition, patients with intolerable/severe toxicities (cardiotoxicity) or toxicities impacting survivorship should consider an alternate option to dab-tram.

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]?

Dab-tram is a take-home therapy that should be prescribed by a neuro-oncology team with expertise in the field and with experience administering these agents. The treating teams should have the resources to monitor the patient regularly for evidence of response or disease progression. Furthermore, there should be expertise available to provide supportive care for toxicities (in particular, dermatologic toxicities) and to monitor for possible serious adverse effects (cardiac or retinal toxicity). Multidisciplinary case conference review including neurosurgeons, pathologists, medical and radiation neuro-oncology should be encouraged.

6. Additional Information

We note this review focuses on the combination of dab-tram for BRAF V600 mutated LGGs. While we strongly support and endorse this use, we feel it important to highlight that BRAF V600 mutations represent only a small portion of BRAF altered LGGs. In these patients with known non-V600 BRAF aberrations, trametinib monotherapy has been shown to be a very active and important second line agent for many patients currently. We feel that any evaluation of these BRAF targeted agents in LGGs that does not include trametinib monotherapy is incomplete. We also feel that while the majority of the evidence pertains to pediatric and young adult patients, older adults can harbor tumors with similar molecular alterations and should be eligible to receive targeted 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 <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.**

   None

Declaration for Clinician 1

Name: Dr. Paul Gibson
Position: Pediatric Oncologist, McMaster Children's Hospital, Associate Medical Director, POGO
Date: 02-12-2024

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

Table 1: Conflict of Interest Declaration for Clinician 1

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

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

Declaration for Clinician 2

Name: Dr. Julie Bennett
Position: Staff Physician, Neuro-Oncology Section, Hospital for Sick Children
Date: 02-12-2024

☒ 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

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

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

Declaration for Clinician 3

Name: Mary Jane Lim-Fat
Position: Neuro-oncologist, Sunnybrook Health Sciences Centre
Date: 02-12-2024

☒ 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**
Novocure	X			
Servier	X			
Add or remove rows as required				

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

Declaration for Clinician 4

Name: Donna Johnston
Position: Staff oncologist, Children's Hospital of Eastern Ontario
Date: 02-12-2024

☐ 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**
Alexion	x			
Servier	x			
Jazz	x			

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

Declaration for Clinician 5

Name: Dr. Chantel Cacciotti
Position: Pediatric Oncologist, Children's Hospital, London Health Sciences Centre
Date: 02-12-2024

☒ 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**
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 6

Name: Dr. Seth Climans
Position: Neuro-oncologist, London Health Sciences Centre
Date: 02-12-2024

☒ 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 6: 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. Vijay Ramaswamy
Position: Staff Neuro-Oncologist, The Hospital for Sick Children
Date: 02-12-2024

☒ 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 7: 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**
Alexion		X		
Servier	X			
Add or remove rows as required				

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

Declaration for Clinician 8

Name: Ms. Tara McKeown
Position: Pediatric Neuro-oncology Nurse Practitioner, The Hospital for Sick Children
Date: 02-12-2024

☒ 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 8: Conflict of Interest Declaration for Clinician 8

	Check appropriate dollar range*			
Company	**$0 to $5,000**	**$5,001 to $10,000**	**$10,001 to $50,000**	**In excess of $50,000**
Alexion	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 9

Name: Mr. Brendan Sudbury
Position: Clinical Oncology Pharmacist, Children's Hospital, London Health Sciences Centre
Date: 02-12-2024

☒ 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 9 Conflict of Interest Declaration for Clinician 9

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

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

Declaration for Clinician 10

Name: Dr. Laura Wheaton
Position: Pediatric Oncologist, Kingston Health Sciences Centre
Date: 04-12-2024

☒ 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 10: Conflict of Interest Declaration for Clinician 10

	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 11

Name: Mr. Michael Sieders
Position: Pediatric Neuro-Oncology Nurse Practitioner, McMaster Children's Hospital
Date: 04-12-2024

☒ 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 11: Conflict of Interest Declaration for Clinician 11

	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 12

Name: Dr. Adam Fleming
Position: Pediatric Neuro-Oncologist, McMaster Children's Hospital
Date: 05-12-2024

☒ 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 12: Conflict of Interest Declaration for Clinician 12

	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 13

Name: Dr. Uri Taboori
Position: Pediatric Neuro-Oncologist, The Hospital for Sick Children
Date: 05-12-2024

☒ 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 13: Conflict of Interest Declaration for Clinician 13

	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.