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

Feedback on Draft Provisional Funding Algorithm

Instructions for Patient, Clinician, and Industry Groups

This form is for eligible patient, clinician, and industry groups to provide feedback and comments on a draft provisional funding algorithm. Input is sought before the project is initiated to help shape the direction and/or the scope of the funding algorithm, whereas feedback is collected when the funding algorithm is near completion (e.g., draft report of the provisional funding algorithm) for refinement.

As described in the Procedures for Reimbursement Reviews, the draft provisional funding algorithm reports are posted for feedback for 7 business days.

We will only consider feedback received from eligible groups (as described in the Procedures for Reimbursement Reviews), including drug manufacturers, patient groups, clinician groups, and the participating drug programs.

If you have any questions regarding the process for provisional funding algorithms, please send an email to requests@cda-amc.ca with the complete details of your question(s).

Before Completing This Form

Please review the following documents to ensure your understanding of our procedures:

- Procedures for Reimbursement Reviews
- Pharmaceutical Review Updates for any new applicable information.

Completing This Form

Feedback should be presented clearly and concisely. Use point form if possible. The issue(s) should be clearly stated and include specific reference to the section of the draft provisional funding algorithm report under discussion (i.e., page number, section title, and paragraph).

Comments should be restricted to the content of the draft report and should not contain any language that could be considered disrespectful or inflammatory or could violate applicable defamation laws.

For panel algorithms, all feedback or comments must relate to implementation and sequencing questions that were considered by the panel. No other aspects will be investigated during this stage of the review process. Feedback on portions of the algorithm not affected by the sequencing questions will not be considered.

If comments in the Feedback section of this form exceed 3 pages, the feedback will not be accepted for review. References may be provided separately, preferably in *JAMA Oncology* citation format. Please use 11-point Arial font for all text and use generic drug names.

Submitting the Completed Form

You can upload the completed form by clicking **Submit Feedback** on the project webpage for the provisional funding algorithm of interest. To ensure fairness in our procedures, all feedback must be received by the deadline posted on the Canada's Drug Agency website.

Important Information About Providing Feedback for Provisional Funding Algorithms

As described in our Procedures for Reimbursement Reviews, the provisional funding algorithm process is used to assist jurisdictions in implementing reimbursement recommendations issued by our expert committees (e.g., pERC or FMEC) and/or making reimbursement policy decisions.

The scope of the provisional funding algorithm is confined to the reimbursement conditions issued by our expert committees. Examples of feedback that may be considered during this stage are comments related to how to improve the clarity of the provisional funded algorithm or how to better depict and describe the funded treatment options within the therapeutic landscape. For example, editorial suggestions or the highlighting of specific reimbursement conditions are welcomed. Note that the depiction of the algorithm and its description must align with all Canada's Drug Agency reimbursement recommendations and conditions.

Feedback related to the reimbursement recommendation of a drug should be submitted directly to the specific reimbursement review. New evidence should not be submitted during the feedback period for the provisional funding algorithm. Provisional funding algorithms are only updated when new evidence has been previously reviewed by an expert committee.

Feedback on Draft Report for Provisional Funding Algorithm

Patient, Clinician, or Industry Group Information

Project number: Enter project number

Condition (or indication) under review: Enter condition or indication

Organization name: Enter organization name

Contact information (if comments require clarification)

Full name: Enter first and last name of contact

Current position: Enter position or title of contact

Email: Enter email address of contact

Phone: Enter phone number of contact

Contact information will not be included in any public posting of this document.

For Both Rapid and Panel Provisional Funding Algorithms (Required)

Q1: Does your group agree with the draft provisional funding algorithm?

☐ Agree with provisional funding algorithm
☐ Partially agree and have comments
☐ Disagree

Please explain the reason(s) for your answer. If possible, identify the specific element from the algorithm with your rationale. Note that algorithms are based on expert committees' recommendations, implementation advice, and the historical jurisdictional funding context.

Click here to describe your reason(s)

Q2: Is the proposed provisional funding algorithm clearly described in the draft report?

☐ No
☐ Yes

Do you have suggestions to improve the clarity of the algorithm? Please provide them here:

Click here to provide suggestions to clarify the algorithm

For Panel Provisional Funding Algorithm Only (Not Required for Rapid Provisional Funding Algorithm)

Q3: Does your group agree with the implementation advice?

☐ Agree with implementation advice
☐ Partially agree and have comments
☐ Disagree

Briefly explain your position on the implementation advice. If possible, identify the specific text in the implementation advice with your rationale.

Click here to describe your position

Q4: Is the rationale for the implementation advice clearly stated and adequately addressed in the report?

☐ No
☐ Yes

Do you have suggestions to improve the clarity of the advice? Please provide them here:

Click here to provide suggestions to clarify the advice

Appendix 1: Conflict-of-Interest Declarations for Patient Groups

- To maintain the objectivity and credibility of the 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 input from patient groups.
- We may contact your group with further questions, as needed.

A. Patient Group Information

Full name: Enter first and last name

Current position: Enter current position or title

Date form completed (dd-mm-yyyy): Select or enter date

☐ **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.

B. Assistance With Providing Feedback

Did you receive help from outside your patient group to complete your feedback?

☐ No
☐ Yes

If yes, please detail the help that was received and who provided it:

Enter details about help received

Did you receive help from outside your patient group to collect or analyze any information used in your feedback?

☐ No
☐ Yes

If yes, please detail the help that was received and who provided it:

Enter details about help received

C. New or Updated Conflict-of-Interest Declaration

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

Table 1: Conflict-of-Interest Declaration for Patient Group

	Approximate amount received			
Company	≤ $5,000	$5,001 to $10,000	$10,001 to $50,000	> $50,000
Enter company name	☐	☐	☐	☐
Enter company name	☐	☐	☐	☐
Enter company name	☐	☐	☐	☐

Note: To add more rows, place cursor in bottom row and select the plus (+) sign on right side of row.

Appendix 2: Conflict-of-Interest Declarations for Clinician Groups

- To maintain the objectivity and credibility of the 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 feedback from clinician groups.
- We may contact your group with further questions, as needed.
- For conflict-of-interest declarations:
  - list any companies or organizations that have provided your group with financial payment over the past 2 years AND that may have direct or indirect interest in the drug under review
  - provide declarations for each clinician that contributed to the input
  - include only new conflict-of-interest declarations or ones that require updating if your clinician group provided input at the beginning of the outset of the review; for all others, please list the clinicians whose provided input is unchanged
  - add more tables as needed (copy and paste)
  - include all new and updated declarations in a single document.

A. Assistance With Providing the Feedback

Did you receive help from outside your clinician group to complete your feedback?

☐ No
☐ Yes

If yes, please detail the help that was received and who provided it:

Enter details about help received

Did you receive help from outside your clinician group to collect or analyze any information used in your feedback?

☐ No
☐ Yes

If yes, please detail the help that was received and who provided it:

Enter details about help received

B. Conflict-of-Interest Declarations

List any companies or organizations that have provided your group or member(s) of your group with financial payment over the past 2 years AND that may have direct or indirect interest in the drug under review. **This is required for *each clinician* that contributed to the input — please add more tables as needed (copy and paste). It is preferred that all declarations be included in a single document.**

Declaration for Clinician 1

Full name: Enter first and last name

Current position: Enter current position or title

Date form completed (dd-mm-yyyy): Select or enter date

☐ **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.

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

Table 2: Conflict-of-Interest Declaration for Clinician 1

	Approximate amount received			
Company	**≤ $5,000**	**$5,001 to $10,000**	**$10,001 to $50,000**	**> $50,000**
Enter company name	☐	☐	☐	☐
Enter company name	☐	☐	☐	☐
Enter company name	☐	☐	☐	☐

Note: To add more rows, place cursor in bottom row and select the plus (+) sign on right side of row.

Declaration for Clinician 2

Full name: Enter first and last name

Current position: Enter current position or title

Date form completed (dd-mm-yyyy): Select or enter date

☐ **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.

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

Table 3: Conflict-of-Interest Declaration for Clinician 2

	Approximate amount received			
Company	**≤ $5,000**	**$5,001 to $10,000**	**$10,001 to $50,000**	**> $50,000**
Enter company name	☐	☐	☐	☐
Enter company name	☐	☐	☐	☐
Enter company name	☐	☐	☐	☐

Note: To add more rows, place cursor in bottom row and select the plus (+) sign on right side of row.

Declaration for Clinician 3

Full name: Enter first and last name

Current position: Enter current position or title

Date form completed (dd-mm-yyyy): Select or enter date

☐ **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.

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

Table 4: Conflict-of-Interest Declaration for Clinician 3

	Approximate amount received			
Company	**≤ $5,000**	**$5,001 to $10,000**	**$10,001 to $50,000**	**> $50,000**
Enter company name	☐	☐	☐	☐
Enter company name	☐	☐	☐	☐
Enter company name	☐	☐	☐	☐

Note: To add more rows, place cursor in bottom row and select the plus (+) sign on right side of row.

Declaration for Clinician 4

Full name: Enter first and last name

Current position: Enter current position or title

Date form completed (dd-mm-yyyy): Select or enter date

☐ **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.

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

Table 5: Conflict-of-Interest Declaration for Clinician 4

	Approximate amount received			
Company	**≤ $5,000**	**$5,001 to $10,000**	**$10,001 to $50,000**	**> $50,000**
Enter company name	☐	☐	☐	☐
Enter company name	☐	☐	☐	☐
Enter company name	☐	☐	☐	☐

Note: To add more rows, place cursor in bottom row and select the plus (+) sign on right side of row.

Declaration for Clinician 5

Full name: Enter first and last name

Current position: Enter current position or title

Date form completed (dd-mm-yyyy): Select or enter date

☐ **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.

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

Table 6: Conflict-of-Interest Declaration for Clinician 5

	Approximate amount received			
Company	**≤ $5,000**	**$5,001 to $10,000**	**$10,001 to $50,000**	**> $50,000**
Enter company name	☐	☐	☐	☐
Enter company name	☐	☐	☐	☐
Enter company name	☐	☐	☐	☐

Note: To add more rows, place cursor in bottom row and select the plus (+) sign on right side of row.