**Stakeholder input on Implementation Advice Request**

Instructions for Stakeholders

This template is for eligible stakeholders to provide input to Canada’s Drug Agency (CDA-AMC) on implementation advice requests. The scope of the implementation advice is posted for input for 10 business days. CDA-AMC will only consider input received from eligible stakeholders (as described in the [*Procedures for Implementation Advice for Health Technologies*](https://www.cadth.ca/sites/default/files/Drug_Review_Process/CADTH_Procedures_for_Implementation%20Advice_for_Health_Technologies.pdf)) including drug manufacturers, patient groups, clinician groups, and the participating drug programs. If you have any questions regarding the process for implementation advice panels, please [contact us](https://www.cda-amc.ca/contact-us) with the complete details of your question(s).

Prior to Completing the Template:

Please review the following to ensure an understanding of the reimbursement review procedures:

* + [Procedures for Implementation Advice for Health Technologies](https://www.cadth.ca/sites/default/files/Drug_Review_Process/CADTH_Procedures_for_Implementation%20Advice_for_Health_Technologies.pdf)
  + [Pharmaceutical Review Updates](https://www.cadth.ca/node/68411?keywords=&result_type%5B%5D=report&product_type%5B%5D=107782&sort=field_date%3Avalue-desc&amount_per_page=10&page=1) for any applicable information.

Completing the Template:

Complete all sections of the template and do not change any of the margin sizes. The maximum size is 5 pages (this total does not include the reference list). Stakeholders must file their commentary within 10 business days of the call for input being issued by CDA-AMC.

As stated in the [*Procedures for Implementation Advice for Health Technologies*](https://www.cadth.ca/sites/default/files/Drug_Review_Process/CADTH_Procedures_for_Implementation%20Advice_for_Health_Technologies.pdf) the input must not contain any confidential information (all information included in the template will be considered disclosable). Stakeholder input should be presented clearly and succinctly in point form, whenever possible. Comments should be restricted to the condition of interest and should not contain any language that could be considered disrespectful, inflammatory, or could be found to violate applicable defamation law.

References must be provided in the following format: In-text citations must be numbered in order of appearance and a numbered reference list must be provided in the JAMA Oncology format.

When the template is complete, delete this cover page and its instructions (including the CDA-AMC document header).

**Patient groups must complete Appendix 1 and Clinician groups must complete Appendix 2**.

Filing the Completed Template:

**Submit the** completed template by clicking *Submit Feedback* on the project webpage for the project. To ensure fairness in the CDA-AMC procedures, all stakeholder feedback must be received by the deadline posted on the CDA-AMC website.

**Stakeholder input on Implementation Advice Request**

1. Stakeholder information

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| --- | --- |
| **Stakeholder information** |  |
| Project number |  |
| Condition under review |  |
| Organization |  |
| Contact informationa | Name: |

a CDA-AMC may contact this person if comments require clarification. Contact information will not be included in any public posting of this document by CDA-AMC.

1. Comments on Implementation Advice Request

Please provide comments on the implementation advice request that has been filed by the drug programs.

Comments should not exceed 5 pages (excluding references) and must not include any must not contain any confidential information (all information included in the template will be considered disclosable by CDA-AMC).

**References**

**Appendix 1. Conflict of Interest Declarations for Patient Groups**

* To maintain the objectivity and credibility of the CDA-AMC 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 patient groups and clinician groups.
* CDA-AMC may contact your group with further questions, as needed.

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| **A. Patient Group Information** | | | | | | | | |
| **Name** | *Please state full name* | | | | | | | |
| **Position** | *Please state currently held position* | | | | | | | |
| **Date** | *Please add the date form was completed (DD-MM-YYYY)* | | | | | | | |
|  | 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** | | | | | | | | |
| 1. **Did you receive help from outside your patient group to complete your feedback?** | | | | | | No | |  |
| Yes | |  |
| If yes, please detail the help and who provided it. | | | | | | | | |
| 1. **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 and who provided it. | | | | | | | | |
| **C. Previously Disclosed Conflict of Interest** | | | | | | | | |
| 1. **Were conflict of interest declarations provided in patient group input that was submitted at the outset of the review and have those declarations remained unchanged? If no, please complete section D below.** | | | | | | No |  | |
| Yes |  | |
| **D. New or Updated Conflict of Interest Declaration** | | | | | | | | |
| 1. **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.** | | | | | | | | |
| **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* | |  |  |  |  | | | |

**Appendix 2. Conflict of Interest Declarations for Clinician Groups**

* To maintain the objectivity and credibility of the CDA-AMC 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 patient groups and clinician groups.
* CDA-AMC may contact your group with further questions, as needed.
* For conflict of interest declarations:
  + Please 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 declarations are required for each clinician that contributed to the input.
  + If your clinician group provided input at the outset of the review, only conflict of interest declarations that are new or require updating need to be reported in this form. For all others, please list the clinicians who provided input are unchanged
  + Please add more tables as needed (copy and paste).
  + All new and updated declarations must be included in a single document.

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| **A. Assistance with Providing the Feedback** | | |
| 1. **Did you receive help from outside your clinician group to complete this submission?** | No |  |
| Yes |  |
| If yes, please detail the help and who provided it. | | |
| 1. **Did you receive help from outside your clinician group to collect or analyze any information used in this submission?** | No |  |
| Yes |  |
| If yes, please detail the help and who provided it. | | |
| **B. Previously Disclosed Conflict of Interest** | | |
| 1. **Were conflict of interest declarations provided in clinician group input that was submitted at the outset of the review and have those declarations remained unchanged? If no, please complete section C below.** | No |  |
| Yes |  |
| If yes, please list the clinicians who contributed input and whose declarations have not changed:   * Clinician 1 * Clinician 2 * *Add additional (as required)* | | |

**C. New or Updated Conflict of Interest Declarations**

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| **New or Updated Declaration for Clinician 1** | | | | | |
| **Name** | *Please state full name* | | | | |
| **Position** | *Please state currently held position* | | | | |
| **Date** | *Please add the date form was completed (DD-MM-YYYY)* | | | | |
|  | **I hereby certify** that I have the authority to disclose all relevant information with respect to any matter involving this clinician or clinician group with a company, organization, or entity that may place this clinician or clinician group in a real, potential, or perceived conflict of interest situation. | | | | |
| **Conflict of Interest Declaration** | | | | | |
| 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. | | | | | |
| **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* | |  |  |  |  |

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| **New or Updated Declaration for Clinician 2** | | | | | |
| **Name** | *Please state full name* | | | | |
| **Position** | *Please state currently held position* | | | | |
| **Date** | *Please add the date form was completed (DD-MM-YYYY)* | | | | |
|  | **I hereby certify** that I have the authority to disclose all relevant information with respect to any matter involving this clinician or clinician group with a company, organization, or entity that may place this clinician or clinician group in a real, potential, or perceived conflict of interest situation. | | | | |
| **Conflict of Interest Declaration** | | | | | |
| 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. | | | | | |
| **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* | |  |  |  |  |

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| **New or Updated Declaration for Clinician 3** | | | | | |
| **Name** | *Please state full name* | | | | |
| **Position** | *Please state currently held position* | | | | |
| **Date** | *Please add the date form was completed (DD-MM-YYYY)* | | | | |
|  | **I hereby certify** that I have the authority to disclose all relevant information with respect to any matter involving this clinician or clinician group with a company, organization, or entity that may place this clinician or clinician group in a real, potential, or perceived conflict of interest situation. | | | | |
| **Conflict of Interest Declaration** | | | | | |
| 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. | | | | | |
| **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* | |  |  |  |  |

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| **New or Updated Declaration for Clinician 4** | | | | | |
| **Name** | *Please state full name* | | | | |
| **Position** | *Please state currently held position* | | | | |
| **Date** | *Please add the date form was completed (DD-MM-YYYY)* | | | | |
|  | **I hereby certify** that I have the authority to disclose all relevant information with respect to any matter involving this clinician or clinician group with a company, organization, or entity that may place this clinician or clinician group in a real, potential, or perceived conflict of interest situation. | | | | |
| **Conflict of Interest Declaration** | | | | | |
| 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. | | | | | |
| **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* | |  |  |  |  |

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| **New or Updated Declaration for Clinician 5** | | | | | |
| **Name** | *Please state full name* | | | | |
| **Position** | *Please state currently held position* | | | | |
| **Date** | *Please add the date form was completed (DD-MM-YYYY)* | | | | |
|  | **I hereby certify** that I have the authority to disclose all relevant information with respect to any matter involving this clinician or clinician group with a company, organization, or entity that may place this clinician or clinician group in a real, potential, or perceived conflict of interest situation. | | | | |
| **Conflict of Interest Declaration** | | | | | |
| 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. | | | | | |
| **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* | |  |  |  |  |