

CADTH Reimbursement Review

CADTH Reimbursement Recommendation

(Final)

Satralizumab (Enspryng)

For the Treatment of Neuromyelitis Optica Spectrum
Disorder

Recommendation: Reimburse With Conditions

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What is the CADTH reimbursement recommendation for Enspryng?

CADTH recommends that Enspryng should be reimbursed by public drug plans for the treatment of neuromyelitis optica spectrum disorder (NMOSD) if certain conditions are met.

What are the conditions for reimbursement?

Enspryng should only be reimbursed if the price is reduced by 80% to 89%.

Which patients are eligible for coverage?

Enspryng should only be covered to treat patients who are aged 12 years and older and have NMOSD that is anti-aquaporin 4 (AQP4) positive. Patients must have had at least 1 relapse of NMOSD in the 12 months before initiation despite an adequate trial of other accessible preventive treatments for NMOSD, or the patient cannot tolerate other preventive treatments for NMOSD. Patients must have an Expanded Disability Status Scale (EDSS) score of 6.5 points or less.

Why did CADTH make this recommendation?

Evidence from 2 clinical trials demonstrated that Enspryng, alone or in combination with immunosuppressants, reduces the frequency of NMOSD relapses compared with placebo. Enspryng is not cost-effective at the submitted price.

Key Messages

- Clinical evidence suggests that Enspryng should be reimbursed for NMOSD in patients who are 12 years and older, anti-AQP4 positive, have had at least 1 NMOSD relapse in the 12 months before initiation despite an adequate trial of other accessible preventive treatments for NMOSD, or the patient cannot tolerate other preventive treatments for NMOSD. Patients must have an EDSS score of 6.5 points or less.
- The price of Enspryng would need to be reduced by 80% to 89% to be considered cost-effective.
- If the price of Enspryng is not reduced to a point that is affordable to public payers, there may be delays in providing the treatment to eligible patients with NMOSD. However, there are other treatments available for the prevention of NMOSD relapses.

What is NMOSD?

NMOSD is a rare, debilitating, immune-related disorder of the central nervous system. People with NMOSD experience acute attacks or relapses that cause damage to the optic nerves and spinal cord, which can result in limited mobility, paralysis, blindness, or death. The incidence of NMOSD ranges from 0.053 to 0.40 per 100,000 people, and the prevalence ranges from 0.51 to 4.4 per 100,000 people.

What is Enspryng?

Enspryng is approved by Health Canada for use alone or in combination with immunosuppressive therapy for the treatment of NMOSD in adolescent and adult patients who are anti-AQP4 positive. It is a medication (antibody) that blocks the effects of interleukin, a protein that plays a key role in the inflammation in the nervous system of people with NMOSD.

How much does Enspryng cost?

Treatment with Enspryng is expected to cost approximately \$132,300 per patient in the first year and \$122,850 per patient in subsequent years.

What other treatments are available for NMOSD?

Immunosuppressants, immunomodulators, and corticosteroids are available for the prevention of NMOSD relapses.

Unmet needs in NMOSD

Most of the currently available medications for the prevention of NMOSD relapses are not specifically approved for this use and are associated with numerous adverse effects that patients with NMOSD find difficult to tolerate. Despite several available medications, there remains a need for drugs that are effective in preventing relapses of NMOSD and have minimal adverse effects.

How much do other treatments cost?

Soliris, Rituxan, Actemra, azathioprine, and mycophenolate mofetil cost \$701,168, \$10,173, \$184,262, \$246 to \$369, and \$541 to \$6,805, respectively, per patient per year.

SATRALIZUMAB (ENSPRYNG — HOFFMANN-LA ROCHE LIMITED)

Therapeutic area: For the treatment of neuromyelitis optica spectrum disorder

Recommendation

The CADTH Canadian Drug Expert Committee (CDEC) recommends that satralizumab should be reimbursed for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult and adolescent patients (aged 12 years or older) who are anti-aquaporin 4 (AQP4) seropositive only if the conditions listed in Table 1 are met.

Rationale for the Recommendation

Two double-blind, randomized controlled trials (RCTs) (Study 898, N = 83; Study 900, N = 95) in patients with NMOSD who were AQP4 seropositive demonstrated improvement in reducing relapses with satralizumab. In Study 898, the hazard ratio (HR) for the time to first adjudicated protocol-defined relapse in the AQP4-seropositive subgroup was 0.21 (95% confidence interval [CI], 0.06 to 0.75), favouring a combination treatment of satralizumab plus immunosuppressants compared with immunosuppressants plus placebo. The HR for the time to first adjudicated protocol-defined relapse in the AQP4-seropositive subgroup in Study 900 was 0.26 (95% CI, 0.11 to 0.63) in favour of satralizumab alone versus placebo. The results from both studies were considered clinically meaningful.

The sponsor's submitted price of satralizumab is \$9,450 per single-dose, pre-filled syringe, with an annual cost in the initial year of \$132,300 and \$122,850 in subsequent years. In the CADTH reanalyses, the incremental cost-effectiveness ratio (ICER) for satralizumab was \$337,535 per quality-adjusted life-year (QALY) compared with no treatment, and the ICER for satralizumab plus immunosuppressants was \$752,179 per QALY compared with immunosuppressants alone. The cost-effectiveness of satralizumab is uncertain due to limitations with the evidence for the comparative effectiveness of satralizumab versus other treatments for NMOSD and the sponsor-submitted economic model. A price reduction is needed to increase the probability that satralizumab as monotherapy or in combination with immunosuppressants would be cost-effective at a \$50,000 per QALY willingness-to-pay (WTP) threshold.

Table 1. Reimbursement Conditions and Reasons

Reimbursement condition	Reason
Initiation	
1. The patient must have had at least 1 relapse of NMOSD in the previous 12 months either 1.1. despite an adequate trial of other accessible preventive treatments for NMOSD 1.2. because the patient cannot tolerate other preventive treatments for NMOSD.	Patients enrolled in Study 900 were required to have experienced at least 1 relapse of NMOSD in the previous 12 months.
2. Patients must have an EDSS score of 6.5 points or less.	Patients enrolled in Study 898 and Study 900 were required to have an EDSS score of 6.5 points or less at baseline.
3. Satralizumab should not be initiated during a NMOSD relapse episode.	Satralizumab acts to prevent, not treat, relapses of NMOSD. There is no evidence to support starting treatment with satralizumab during a NMOSD relapse episode.
4. The maximum duration of initial authorization is 12 months.	Authorization of funding for 12 months provides flexibility to accommodate the practical challenges of assessing clinical response after treatment initiation given the natural history of NMOSD.
Renewal	
The physician should measure and provide EDSS scores every 6 months after the initial authorization to determine if the continuation of satralizumab reimbursement should occur.	Clinical expert input indicated that maintenance treatment response would be assessed every 6 months after the initial treatment period. Given this input and the clinical course of NMOSD, CDEC concluded that treatment response should be assessed every 6 months after the initial period of authorization (see Initiation Condition 4 and Discontinuation Condition).
Discontinuation	
Reimbursement of satralizumab treatment should be discontinued if the patient's EDSS score is 8 points or greater.	Neither study applied defined study treatment discontinuation criteria. Given the natural history of NMOSD, CDEC concluded that preventive treatment for relapse is likely of limited clinical benefit when patients are severely disabled, corresponding to an EDSS score of 8 points or more.
Prescribing	
The prescribing of satralizumab for the treatment of NMOSD should be restricted to a neurologist with expertise in treating NMOSD.	Accurate diagnosis of NMOSD is important to ensure that satralizumab is prescribed to the appropriate patients. In addition, several treatment options must be considered when selecting the most appropriate therapy for patients who have NMOSD.
Pricing	
A reduction in price	Satralizumab is more costly as monotherapy versus no treatment or in combination with immunosuppressants versus immunosuppressants alone. A price reduction of 80% to 89% would be required for satralizumab to be considered cost-effective compared to no treatment or immunosuppressants at a WTP threshold of \$50,000 per QALY.

CDEC = CADTH Canadian Drug Expert Committee; EDSS = Expanded Disability Status Scale; NMOSD = neuromyelitis optica spectrum disorder; QALY = quality-adjusted life-year; WTP = willingness to pay.

Discussion Points

- Patient group input put a high priority on the need for a treatment to reduce disease attacks and allow patients to remain at home to receive therapy. In addition, the patient input identified improved symptoms, reduced disability, and improved quality of life as valued outcomes associated with treatments for NMOSD. The effects of satralizumab on pain and fatigue were evaluated as key secondary outcomes in Study 898 and Study 900. However, no statistically significant differences between groups for the change from baseline to week 24 in pain visual analogue scale (VAS) score or the Functional Assessment of Chronic Illness Therapy–Fatigue (FACIT-F) scores in both studies. Input from clinical experts noted that satralizumab was not expected to directly impact pain or fatigue. Similarly, the effects of satralizumab on health-related quality of life and functional outcomes also did not demonstrate a difference with satralizumab versus comparators in Study 898 and Study 900. However, these were evaluated as other outcomes in both studies; therefore, the trials were not adequately designed to detect between group treatment differences.
- The efficacy data from Study 898 and Study 900 are based on analyses of a pre-specified subgroup of patients with NMOSD and AQP4 antibody positive. Approximately two-thirds of patients enrolled in each study were AQP4 seropositive at baseline. Results were more difficult to interpret because of the smaller sample sizes, analyses that did not control for multiplicity, and patient randomization that was not stratified at baseline on AQP4 antibody status; however, CDEC concluded that these limitations did not have a meaningful impact on the results of the studies. As well, the AQP4-seropositive subgroup is the population specified in the Health Canada–approved indication for satralizumab.
- The reviewed RCTs had different eligibility criteria related to the frequency of relapses of NMOSD. Study 898 enrolled adolescents and adults who had had at least 2 relapses in the 2 years before study start, 1 of which had to have occurred in the previous 12 months. Study 900 included adult patients who had had at least 1 relapse in the year before study start, including a first attack. Given the natural history of NMOSD, the potentially debilitating effects of relapses, and the available evidence, CDEC concluded that the conditions for initiation are supported by the number of prior relapses of NMOSD used in Study 900.
- CDEC noted that both Study 898 and Study 900 required patients to have an EDSS score of 6.5 points or less to be eligible for the RCTs. The mean baseline EDSS scores for patients in the satralizumab groups were 4.3 (standard deviation [SD] = 1.6; median = 4.0; range = 1.0 to 6.5) and 4.0 (SD = 1.5; median = 4.0; range = 1.0 to 6.5) in the AQP4-seropositive subgroups of Study 898 and Study 900, respectively. Therefore, the currently available evidence for the efficacy of satralizumab as monotherapy or in combination with immunosuppressants is in patients with an EDSS score of 6.5 or less at treatment initiation.
- Patients were excluded if they had used rituximab before screening and they were not permitted to use rituximab during the study because its mechanism of action overlaps with satralizumab in reducing plasmablasts. CDEC heard clinician input that rituximab is potentially used as a therapy for the prevention of relapses in NMOSD. Therefore, the generalizability of results of Study 898 and Study 900 among patients with a history of use of rituximab is uncertain.
- Direct comparative efficacy and harms data for satralizumab versus immunosuppressants, eculizumab, or rituximab are presently unavailable. An indirect treatment comparison (ITC) provided by the sponsor estimated the relative treatment effects and safety of satralizumab versus eculizumab. However, the analysis was associated with significant limitations such as a small sample and unresolved differences between the included trials that meant many of the assumptions for the analysis were likely not met. The results of the ITC were highly uncertain, and no conclusions can be drawn on the comparative efficacy and safety of satralizumab versus eculizumab in patients who have NMOSD and are AQP4 antibody positive.
- Two longer-term extension studies suggested continued benefit with respect to fewer relapses with satralizumab treatment, but the results were limited by the open-label and observational designs and differences in the definition of relapses compared with what was used in Study 898 and Study 900.
- There were no signals for an increase in serious adverse events within the RCTs relative to the comparators.

Background

Satralizumab has a Health Canada indication for use as monotherapy or in combination with immunosuppressive therapy for the treatment of NMOSD in adult and adolescent patients who are anti-AQP4 seropositive. Satralizumab is an interleukin receptor inhibitor immunosuppressant. It is available as a 120 mg/mL single-use, pre-filled syringe, and the Health Canada–approved loading dose is 120 mg by subcutaneous injection at weeks 0, 2, and 4 for the first 3 administrations, followed by a maintenance dose of 120 mg every 4 weeks. Satralizumab is not intended for acute treatment of an NMOSD relapse.

Summary of Evidence

To make their recommendation, CDEC considered the following information:

- a systematic review that included 2 RCTs in patients with NMOSD
- patient perspectives gathered by 1 patient group, the Multiple Sclerosis Society of Canada
- four clinical specialists with expertise diagnosing and treating patients with NMOSD
- a review of the pharmacoeconomic model and report submitted by the sponsor.

Summary of Patient Input

The Multiple Sclerosis Society of Canada provided input for this submission. Patient perspectives were obtained from an online survey that received responses from 37 people, including 25 respondents (68%) who had been diagnosed with NMOSD. The following is a summary of key input from the perspective of the patient group:

- NMOSD is a severe and debilitating autoimmune disease characterized by relapses that may result in permanent and life-changing neurological deficits. Patients with NMOSD report experiencing pain, muscle weakness, paralysis, loss of vision, and bladder or bowel control problems caused by relapses. The accrued disability leads to employment instability or loss, increased need for assistance or caregiving, loss of independence, isolation, cognitive decline, and increased mobility challenges.
- There is a need for safe and effective relapse-prevention treatments for patients with NMOSD, as early intervention to eliminate relapses is key to averting disability and improving longer-term outcomes for patients.
- Patients hope that satralizumab will reduce attacks and disability and allow patients to self-administer their therapy at home. Treatment with satralizumab has the potential to allow people living with NMOSD to remain in the workforce, sustain family and social roles and responsibilities longer, improve their quality of life, and decrease the need for family or paid caregivers.

Clinical Trials

The systematic review included 2 double-blind RCTs of patients with neuromyelitis optica (NMO) or NMOSD (Study 898 and Study 900). Patients were randomized to placebo or satralizumab 120 mg subcutaneous injection at weeks 0, 2, and 4 and every 4 weeks thereafter.

Study 898 enrolled 83 adults and adolescents (12 years to 74 years of age), of whom 55 (66%) were AQP4 antibody positive (i.e., the indicated population). The patients enrolled had at least 2 relapses in the past year (1 of which occurred in the last 12 months) and all received background immunosuppressant treatment of azathioprine, mycophenolate mofetil, or corticosteroids during the trial. Study 900 enrolled 95 adults, aged 18 to 74 years, who had at least 1 relapse in the past year, including a first attack. The AQP4 antibody–positive subgroup included 64 patients (67%). Both were event-driven trials that were designed to stop once 26 primary outcome relapse events were reported (in Study 898) or when 44 primary outcome relapse events had occurred or 1.5 years after the last patient was randomized (in Study 900). The median treatment duration was 33 weeks and 107 weeks for Study 898, and 55 weeks and 92 weeks in Study 900, for the placebo and satralizumab groups, respectively.

The review of the evidence focused on the results in the AQP4 antibody–positive subgroup because this is the indicated population in Canada.

Outcomes

Outcomes were defined a priori in CADTH's systematic review protocol. Of these, the committee discussed the following:

- Occurrence of relapses of NMOSD, measured in the studies as time to first protocol-defined or clinical relapse. A protocol-defined relapse was any new or worsening neurological symptom attributable to NMO or NMOSD that persisted for a minimum of 24 hours that was not attributable to confounding clinical factors and met the predefined criteria for a change in EDSS or Functional System Score (FSS) score. All events were confirmed by a blinded, independent adjudication committee. A clinical relapse was defined as any relapse reported by the investigator without adjudication.
- Changes in pain measured using a VAS.
- Changes in fatigue symptoms based on FACIT-F scores. The FACIT-F scale is a 13-item questionnaire that measures a patient's level of daily fatigue over the past week. The total ranges from 0 to 52, where 0 is the worst possible score and 52 the best score (less fatigue).
- Changes in disability measured with the EDSS and the modified Rankin Scale. The EDSS is a quantitative measure of disability that is based on a standard neurological examination. It is an ordinal scale that ranges from 0 points (normal neurological examination) to 10 points (death) which increases in half-point increments once an EDSS of 1.0 has been reached. EDSS steps 1.0 to 4.5 refer to people who are fully ambulatory, and steps 5.0 to 9.5 are defined by impairment to ambulation. The modified Rankin Scale is a clinician-reported scale for measuring the degree of disability or dependence in the daily activities of people who have suffered from a neurological disability. The scale ranges from 0 (no disability) to 6 (death).
- Changes in health-related quality of life measured using the Short-Form (36) Health Survey (SF-36) and the EuroQol 5-Dimension (EQ-5D) instruments.
- Harms.

The primary outcome in both trials was the time to first adjudicated, protocol-defined relapse for the intention-to-treat (ITT) population.

Efficacy

For the AQP4 antibody-positive subgroup in Study 898, 43% of patients in the placebo plus immunosuppressant group and 11% in the satralizumab plus immunosuppressant group experienced an adjudicated, protocol-defined relapse, with an HR of 0.21 (95% CI, 0.06 to 0.75; $P = 0.0086$ not controlled for type I error). In the AQP4 antibody-positive subgroup of Study 900, 57% of patients in the placebo group and 22% in the satralizumab group experienced a protocol-defined relapse, with an HR of 0.26 (95% CI, 0.11 to 0.63; $P = 0.0014$ not controlled for type I error). These differences were considered clinically meaningful based on clinical expert input.

In the AQP4 antibody-positive subgroup of Study 898, 68% of patients in the placebo group and 41% in the satralizumab group had a clinical relapse (HR = 0.53, 95% CI, 0.25 to 1.12; $P = 0.092$ not controlled for type I error). For this subgroup in Study 900, 61% and 46% of patients in the placebo and satralizumab groups, respectively, experienced a clinical relapse, with an HR of 0.51 (95% CI, 0.25 to 1.03; $P = 0.056$ not controlled for type I error).

Results suggest a reduction in the annualized relapse rate (ARR) for satralizumab versus placebo in Study 898 (ARR ratio = 0.3, 95% CI, 0.1 to 0.8; $P = 0.018$ not adjusted for type I error), but not for Study 900 (ARR ratio = 0.3; 95% CI, 0.1 to 1.1; $P = 0.067$ not adjusted for type I error rate). These results were only considered supportive of the effects of satralizumab on relapses because the ARR was reported for the full ITT population only and not for the AQP4 antibody-positive subgroup, and patients were censored at the time of their first relapse and subsequent relapses were not captured, thereby likely underestimating the ARR.

No statistically significant differences were detected between groups for the change from baseline to week 24 in pain VAS score or FACIT-F scores for the full ITT populations in both studies (key secondary outcomes). Pain and fatigue data for the AQP4 antibody-positive subgroup were similar to the results in the overall study populations.

The trials did not report health-related quality of life or disability outcomes for the AQP4 antibody–positive subgroup. No differences were found between groups based on the ITT population in either study for the change from baseline in EDSS score, modified Rankin Scale score, visual acuity, EQ-5D, or SF-36.

Harms (Safety)

The percentage of patients who experienced an adverse event ranged from 75% to 95% in the placebo groups and from 90% to 92% in the satralizumab groups. After adjusting for follow-up time, the rate of adverse events was 495 events to 514 events per 100 person-years (PY) among those assigned to the placebo, and from 474 events to 485 events per 100 PY for those who received satralizumab.

The most common adverse events were urinary tract infections, upper respiratory tract infections, headache, nasopharyngitis, and injection-related reactions. The rate of infections ranged from 150 events to 163 events per 100 PY among those randomized to the placebo, and from 100 events to 133 events per 100 PY to those who received satralizumab.

Serious adverse events were reported in 16% to 21% of patients assigned to the placebo and 17% to 19% of patients who received satralizumab, with a serious adverse event rate of 15 events to 20 events per 100 PY and 12 events to 17 events per 100 PY in the placebo and satralizumab groups, respectively. More patients stopped treatment due to adverse events in the add-on therapy trial (Study 898: placebo = 12%; satralizumab = 7%) than in the monotherapy trial (Study 900: placebo = 3%; satralizumab = 2%).

No deaths, hepatotoxicity, or anaphylaxis events were reported in either study.

Indirect Evidence

The sponsor submitted an ITC that estimated the relative treatment effects and safety of satralizumab versus eculizumab or inebilizumab; the latter is not currently available in Canada. Bayesian network meta-analysis (NMA) methods were used to combine data from 4 RCTs, including a subgroup analysis in patients who were AQP4 antibody positive. The NMA results for the time to first protocol-defined relapse did not differentiate between satralizumab and eculizumab, or between satralizumab and placebo, and showed wide 95% credible intervals indicating limited precision around the treatment effect estimates. A similar pattern of results was observed for the analyses of ARR, proportion of relapse-free patients at 48 weeks, change in EDSS score at 48 weeks, withdrawals due to adverse events, and rate of serious infections.

Although the NMA was conducted using accepted statistical methods, there were many differences between study populations, study designs, effect modifiers, and end point definitions in the trials that were not adequately addressed. Combined with the sparse network for the analyses, the results of the NMA are highly uncertain and no conclusions can be drawn on the comparative efficacy and safety of satralizumab versus eculizumab in patients who have NMOSD and are AQP4 antibody positive.

Cost and Cost-Effectiveness

At a submitted price of \$9,450 per pre-filled syringe, the annual per patient cost of satralizumab in the first year is \$132,300 and \$122,850 in subsequent years.

The sponsor submitted 2 cost-utility analyses assessing satralizumab, with or without maintenance immunosuppressants, for the treatment of adolescents and adults with NMOSD who are AQP4 seropositive. Satralizumab as monotherapy was compared with no treatment in 1 model and in combination with maintenance immunosuppressants (i.e., azathioprine, mycophenolate mofetil or corticosteroids) compared with maintenance immunosuppressants alone in the second model. The economic analysis was conducted from the perspective of the public health care payer over a lifetime time horizon (defined as 50 years). The cost-utility models shared a common Markov structure in which health states were defined by the EDSS to reflect the impact of relapses on disease severity and health-related quality of life. The model consisted of 10 EDSS health states (i.e., EDSS 0 to 9) along with an absorbing death health state. At the start of the model, patients had a range of EDSS scores and could either remain in the same EDSS state (reflecting stable disease), experience a relapse (i.e., move to a higher EDSS state), or die after each cycle. Patients could not improve (i.e., move to lower EDSS scores) following recovery from a relapse and were assumed to remain on satralizumab until discontinuation. Treatment efficacy was measured as time to first adjudicated protocol-defined relapse taking data from studies

900 and 898 for satralizumab compared with no treatment and satralizumab plus immunosuppressants compared with immunosuppressants alone, respectively. Health state and caregiver utility values were derived from Study 898, Study 900, and the published literature. The frequency of adverse events was based on data from Study 898 and Study 900.

CADTH identified several key limitations with the submitted analysis:

- The submitted cost-utility analyses do not fully reflect the expected place in therapy for satralizumab. Given the absence of comparative clinical evidence for satralizumab alone compared with immunosuppressants alone, the cost-effectiveness of satralizumab versus immunosuppressants remains unknown.
- The relapse definition used by the sponsor in the model was based on adjudication by an independent committee, which does not reflect Canadian practice.
- Natural history was modelled based on EDSS; however, the validity and reliability of this approach in patients with NMOSD is unknown. Concerns were also raised by the clinical experts consulted by CADTH with the database selected to inform natural history estimates because expected life-years were likely overestimated in both the treatment and comparator arms.
- Caregiver disutilities were applied, which misaligns with the public health care payer perspective.
- Frequency of adverse events were based on the respective clinical studies. Although fewer adverse events were observed in the satralizumab plus immunosuppressant group compared with immunosuppressants alone in Study 898, these observed differences were likely due to chance and may not be observed in clinical practice.

CADTH attempted to address the identified limitations in both economic models by changing the relapse definition and removing caregiver disutilities. In addition, for the economic model for satralizumab plus immunosuppressants compared with immunosuppressants alone, CADTH assumed no differences in the frequency of adverse events between groups. In the CADTH base case, the ICER for satralizumab was \$337,535 per QALY compared to no treatment and the ICER for satralizumab plus immunosuppressants was \$752,179 per QALY compared to immunosuppressants. An 80% price reduction is required for satralizumab monotherapy and an 89% price reduction is required for satralizumab combination therapy for the drug to be considered cost-effective at \$50,000 per QALY threshold.

CADTH was unable to address inherent limitations with the economic model and the uncertainties resulting from the overestimation of life-years. Importantly, the economic analyses do not address the cost-effectiveness of satralizumab versus immunosuppressants.

CDEC Members

Dr. James Silvius (Chair), Dr. Ahmed Bayoumi, Dr. Sally Bean, Dr. Bruce Carleton, Dr. Alun Edwards, Mr. Bob Gagne, Dr. Ran Goldman, Dr. Allan Grill, Mr. Allen Lefebvre, Dr. Kerry Mansell, Ms. Heather Neville, Dr. Danyaal Raza, Dr. Emily Reynen, Dr. Yvonne Shevchuk, and Dr. Adil Virani.

March 17, 2021, Meeting

Regrets

None.

Conflicts of Interest

None.

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