CADTH REIMBURSEMENT REVIEW

Patient and Clinician Group Input

talquetamab (Talvey)

(Janssen Inc.)

Indication: For the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least three prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent and an anti-CD38 monoclonal antibody, and have demonstrated disease progression on or after the last therapy.

May 13, 2024

This document compiles the input submitted by patient groups and clinician groups for the file under review. The information is used by CADTH 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.

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CADTH

Patient Group Input

Name of Drug: talquetamab (TALVEY)

Indication: Adult patients with relapsed-refractory multiple myeloma who have received at least 3 prior lines of therapy, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 antibody; and have demonstrated disease progression on their last therapy.

Name of Patient Group: Myeloma Canada

Author of Submission: Aidan Robertson [redacted]

1. About Your Patient Group

Multiple myeloma, also known as myeloma, is the second most common form of blood cancer. Myeloma affects plasma cells, which are a type of immune cell found in the bone marrow. Every day, 11 Canadians are diagnosed with myeloma, yet despite its growing prevalence the disease remains relatively unknown. People with myeloma experience numerous relapses; with successful treatment it can enter periods of remission, but myeloma will always ultimately return and require further treatment. Myeloma patients also become refractory to a treatment, meaning it can no longer control their myeloma, and they require a new regimen. Myeloma Canada has existed for over 15 years to support the growing number of Canadians diagnosed with myeloma, and those living longer than ever with the disease can access new and innovative therapies. Over the years, as a part of this mission Myeloma Canada has collected data on the impact of myeloma and its treatments on patients and caregivers by conducting surveys. The data are then presented to the pERC.

www.myeloma.ca

1. Information Gathering

Myeloma Canada is sharing the input received from a patient and caregiver survey regarding talquetamab, a GPRC5D targeted, t-cell engaging, bispecific antibody therapy for the treatment of relapsed refractory multiple myeloma. Our patient and caregiver survey was available from April 17 – May 10, 2024, and was shared across Canada and internationally, via email and social media. Of 86 total responses to the survey, 9 incomplete responses wherein a respondent did not finish answering survey questions, and 39 disqualified responses wherein the respondent's answers indicated they did not meet the eligibility requirements were removed from the dataset, leaving 38 complete and eligible responses.

Survey eligibility was determined by patient and caregiver self-report of their experience with myeloma, that they (or the person they care for) have relapsed/refractory myeloma, received at least three prior

lines of therapy including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 antibody, All 32 patients (Subset E: 27 + Subset T: 5 = 32) and 6 caregivers (Subset E: 5 + Subset T: 1=6) were initially asked similar questions regarding disease experience. Upon verifying their eligibility for, or experience with, the treatment under review, respondents were divided into two subsets, and correspondingly posed different questions. The subsets and their demographic characteristics are as follows:

1. Patients who would currently be eligible for treatment with talquetamab and their caregivers: **Subset E.** Respondents **(32)** were from Alberta (1), British Columbia (8), Nunavut (1), Manitoba (1), Ontario (18), Quebec (2), and 1 from outside of Canada (France). 27 of 32 respondents were patients, and 5 were caregivers. Of 32 Subset E respondents, 17 identified themselves as assigned male at birth (further referred to in this report as male), and 15 as assigned female at birth (further referred to in this report as female). 25 Subset E respondents resided in an urban area, and 6 in a rural area (1 respondent skipped the question). 2 Subset E respondents were between '40—49' years of age, 1 was between '50–59', 14 were between '60–69', 14 were between '70–79' years, and one final respondent was between '80–89' years old.
2. Patients who have received or are currently receiving treatment with talquetamab and their caregivers: **Subset T.** Respondents **(6)** were from Alberta (4), Quebec (1), and Ontario (1). 5 of 6 respondents were patients, one was a caregiver. 4 respondents identified themselves as female, 2 as male. Respondents (6) were predominantly located in an urban area (5), and one living in a rural area. 5 respondents from Subset T indicated they were between '70–79' years of age and 1 respondent skipped this question.

2. Disease Experience

All respondents (38) were asked "*Please rate on a scale of 1 - 5, how important it is for you to control various aspects related to myeloma. 1 is 'Not important', 5 is 'Extremely important'.",* by weighted average rating, respondents indicated that 'Infections' (4.54) were the most important aspect to control, followed by 'Fatigue' (4.02), 'Kidney problems' (4), and 'Pain' (3.98).

When asked "*Rate on a scale of 1–5 (1 is No impact and 5 is Extreme impact'), how symptoms associated with myeloma impact or limit your day-to-day activities and quality of life.",* by weighted average rating, respondents (38) indicated that their 'ability to travel' (3.4) was most significantly impacted, followed by 'ability to exercise' (3.28), and 'ability to conduct volunteer activities' (3.18).

When all respondents (38) were asked "*How long does it take you to make a round-trip (to and from) the hospital/cancer centre where you, or the person you care for, receive(s) treatment?",* most respondents (19) indicated 'Less than 1 hour one way',14 respondents chose '1–2 hours (30mins – 1h one way)', 3 chose '5 hours or more (2.5 hours or more one way)', 2 chose '3–4 hours (1h – 2hrs one way)', and one respondent chose 'Other' commenting that they self-administer treatment at home with the help of their caregiver.

When all patients and caregivers (38) were asked how often they, or the person they care for, visit their hospital or cancer centre for treatment, respondents most frequently selected, 'once a month (15), followed by 'every two weeks'

(11), ‘once a week’ (7), and ‘every two months’ (1). 4 respondents selected ‘other’, two of which indicated they receive/take treatment at home, one commented: “*2 or 3 days out of every month”,* and the other described “*every month visit the …Hospital 3 times - 3 days over 1 week period”.*

When patients and caregivers (38) were asked, “*What is the most significant financial implication of myeloma treatment on you and your household? If there is more than one implication, please check all that apply”*; respondents indicated travel costs (16), followed by parking costs (15), lost income/pension funds due to absence from work, disability, or early retirement (10), drug costs (10), and accommodation costs (9) were the most significant financial implications of myeloma treatment.

All patients and caregivers were asked *Has multiple myeloma, or caring for someone with myeloma, resulted in any of the following psychological / social difficulties for you? Please rate on a scale of 1–5 how severely they impacted your quality of life (1 – No impact and 5 – Severe impact)’*. By the weighted average of responses, respondents (38) felt that that ‘Interruption of life goals/accomplishments (career, retirement, etc.)’ (3.42) had the most impact on quality of life, and it was the option most frequently (8) rated 5 – Severe impact. Responses also indicated ‘Loss of sexual desire’ (3.03) and ‘Anxiety/worry’ (2.99) had more significant impacts on quality of life.

When all patients (31) were asked “*Do you need the support of a caregiver or family member to help you manage your myeloma or your treatment-related symptoms?”*, most responded ‘Yes’ they required a caregiver (15), 10 answered ‘No’ they did not need a caregiver, 4 chose ‘No’, but I would benefit from a caregiver’s help, and 2 chose ‘Yes but I am unable to access the help I need’.

All patients and caregivers were asked to identify the factors they consider to be most important to (any) myeloma treatment. Respondents (37) frequently mentioned maintaining quality of life and making side effects manageable, along with the effectiveness of treatment, especially in achieving remission and having a long, durable, response, and accessibility/portability of treatment (including fewer/minimal visits to the hospital/cancer centre), to be key factors. Responses to this effect are as follows:

“Effective and reasonably side effect free or side effects that can be managed”; “Extension of life expectancy with manageable side effects for quality of life.”;

“*-effective -oral when possible -short term- eg cart-T - able to access despite being continually on many different multiple treatments over 19 years.”;*

“Quality of Life needs to be very good, combined with longevity.”; “Side effects, and location of treatment ”;

“Treatment near-by, spend time with family and friends, no infections.”.

3. Experiences With Currently Available Treatments (eligible population Subset E)

After determining that all respondents had received treatment with all three main classes of therapy (PI, IMiD, and anti-CD38 antibody), Subset E (32) was asked “*How many prior lines of therapy have you or the person you care for received?”,* 19 respondents (59.38%) indicated they received 3 lines of therapy, 9 (28.13%) responded 4 lines of therapy, and 4 respondents indicated they or the person they care for, had received 5 lines of therapy or more.

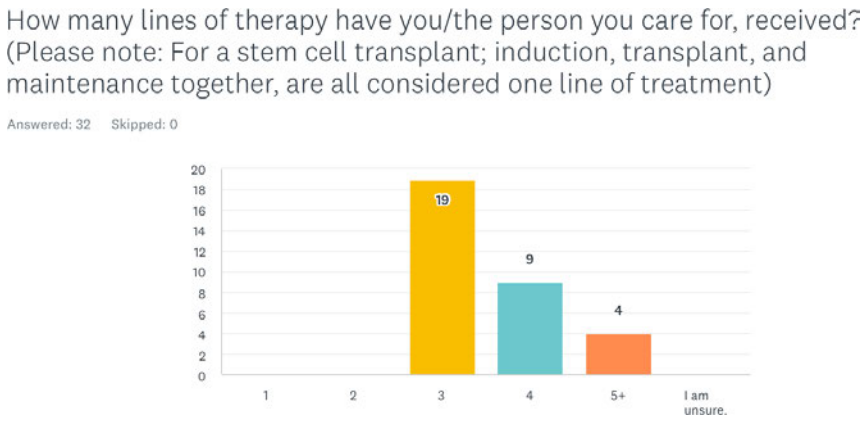

Figure 1 – Number of lines of therapy received (Subset E; 32)

When asked, "*Have you/the person you care for, received an autologous stem-cell transplant (ASCT) to treat your myeloma?"* 96.88% of Subset E respondents (31) said yes, and 1 indicated they/the person they care for was not eligible for an ASCT.

4. Improved Outcomes

Subset E (31) was posed the question, "*When considering a myeloma treatment for yourself, how important is it for the treatment to improve your overall quality of life? Rate on a scale of 1 – 5, 1 is 'Not important' and 5 is 'Extremely important'*.", 67.74% (21) of respondents felt it was 5 – extremely important, while 29.03% (9) answered '4 – very important', and 1 chose '3 – somewhat important'.

Subset E (32) was asked how desirable an estimated minimum 1 year+ of extended life is to them at this stage in their myeloma journey, 65.63% (21) indicated it was '5 – extremely desirable', and 28.13% (9) chose '4 – very desirable', 1 chose '3 – somewhat desirable' and 1 chose '1 – not at all desirable'.

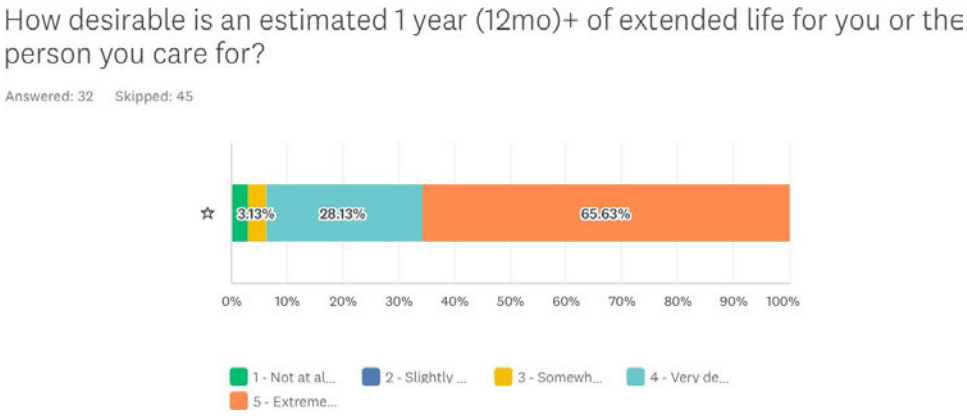

Figure 2 –Desirability of 1+ years extended life (Subset E; 32)

Subset E (32) was presented information about common side effects of talquetamab: Cytokine Release Syndrome, Infections, Neutropenia, Immune Effector Cell Associated Neurotoxicity Syndrome (ICANS), nail-related issues, oral-related issues, and skin-related issues. As well the step-up dosing period, and dosing schedule (weekly) were

described.

Subset E was asked "*Amongst the most common side effects in patients who receive talquetamab, how tolerable do you expect they would be for you or the person you care for? Please rate on a scale of 1 Not at all tolerable to 5 Extremely tolerable'".* Ordered by weighted average of responses Subset E perceived ICANS (2.19), cytokine release syndrome (2.19), and infections (2.28) to be the least tolerable side effects, followed by diarrhea (2.44) and neutropenia (2.48). Overall, the median tolerability rating was 3 – Somewhat tolerable for all side effects except ICANS, CRS, and Infections which received a median rating of '2 – Slightly tolerable'.

When Subset E (32) was asked, "*Compared to other treatment options available to you or the person you care for, how worrisome is the overall side effect profile for talquetamab? Please rate on a scale of 1–5 where 1 is 'Not at all worrisome' and 5 is 'Extremely worrisome'.*" respondents most frequently chose '3 – Somewhat worrisome' (59.38%; 19), followed by, '2 – Slightly worrisome' (18.75%; 6), and '4 – Significantly worrisome' (15.63%; 5). One respondent each chose '1 – Not at all worrisome' and '5 – Extremely worrisome'.

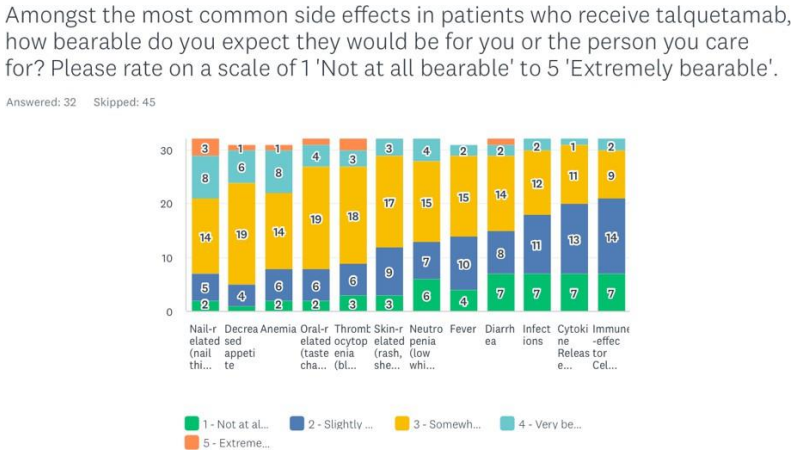

Figure 3 – Perception of talquetamab side effects (Subset E; 32)

Subset E was asked "*Most patients in the MonumenTAL-1/2 trial experienced CRS, and for almost all patients it was either Grades 1 or 2 (i.e. less severe). 1 patient experienced grade 3 CRS and there were NO grade 4 or 5 CRS events. Does knowing this information impact your level of concern about experiencing CRS due to talquetamab, for you or the person you care for?".* Respondents (32) most frequently chose 'No, my level of concern/worry remains the same' (62.5%; 20), followed by 'Yes, I am less worried' (25%; 8), and 'Yes', I am more worried (12.5%; 4).

Subset E was asked "*Most patients in the MonumenTAL-1/2 trial experienced nail, skin, and/or oral- related issues, though for most patients these were manageable. Dose adjustments and supportive care were available to help mitigate the side effects, and only 5 of 288 patients receiving talquetamab discontinued treatment due to these side effects. Does knowing this information impact your level of concern about you or the person you care for experiencing nail, skin, and/or oral-related side-effects due to talquetamab treatment?".* Respondents (32) most frequently chose 'No, my level of concern/worry remains the same' (53.13%; 17), followed by 'Yes, I am less worried' (43.75%; 14), and only one respondent chose 'Yes, I am more worried'.

When asked, "*If you or the person you care for were eligible to receive talquetamab, what do you believe the advantages and/or disadvantages would be?*". Subset E respondents (31) were provided the following list of factors and asked to indicate if they felt there would be an increase or decrease in that area: Treatment side effects (Increased: 17, No change: 4, Decreased: 3, I'm not sure: 7) Control of myeloma and its symptoms'(Increased: 17, No change: 2 , Decreased: 4, I'm not sure: 8), Frequency of trips to the hospital or cancer centre for treatment (Increased: 9, No change: 113, Decreased: 1, I'm not sure: 7), Tolerability of the treatment's mode of administration (Increased: 7, No change: 16, Decreased: 2, I'm not sure: 6), Quality of life (Increased: 15, No change: 4, Decreased: 4, I'm not sure: 8). Many patients indicated they were unsure of the impact talquetamab would have on all factors, while there was the greatest consensus on talquetamab providing increased control of myeloma and its symptoms (17), and there being an increase in treatment side effects (17).

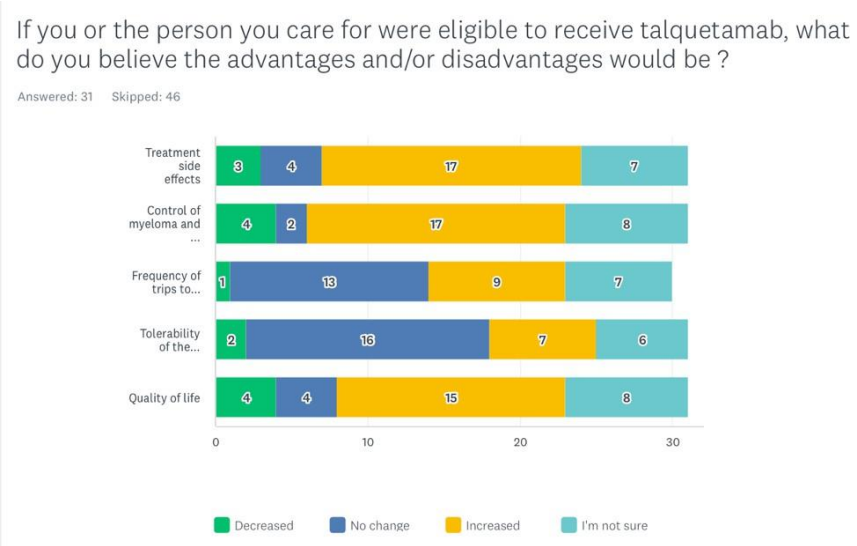

Figure 4 – Perceived advantages/disadvantages of treatment with talquetamab; subset E (31)

To the question "*With what you know today, would you consider talquetamab as an option for your next treatment? (Presuming you are eligible, and your doctor agrees).*" 62.5% (20) of Subset E respondents (32) indicated 'Yes', while 21.88% (7) said they were unsure, and 5 additional patients indicated they would need more information to decide.

When given the opportunity to share any further thoughts about potential treatment with talquetamab, 7 Subset E respondents left comments, of which some noted the importance of their hematologist/oncologist's opinion about talquetamab, and the side effects being manageable, while others described being happy with their current treatment but glad to know this treatment is on the horizon for when they relapse, and one comment noted they were unsure if their next option would be teclistamab or talquetamab.

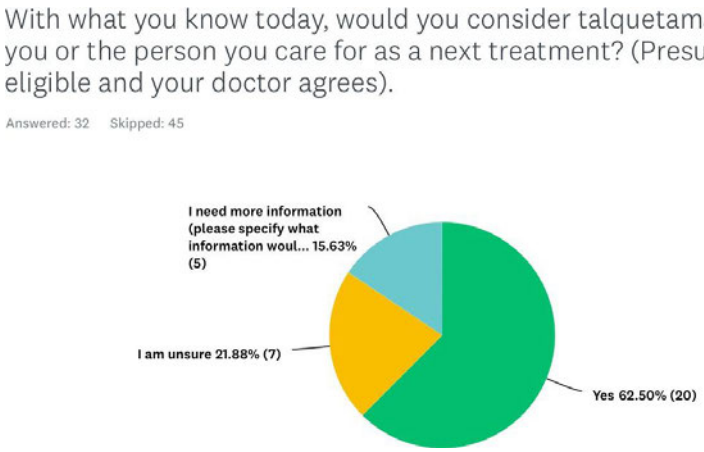

Figure 5 —Would you consider talquetamab for your next treatment? (Subset E; 32)

5. Experience With Drug Under Review

As noted previously, there were 6 individuals with talquetamab experience who responded to the survey, 5 patients and 1 caregiver, and they are referred to as Subset T. When asked to "*…indicate when you or the person you care for began treatment with talquetamab*.", 2 Subset T patients (6) chose 'Less than three months ago', 1 chose 'Over a year ago', 1 chose 'Between 3–6 months ago', 1 chose 'Between 6- 12 months ago', and 1 chose 'Over 2 or more years ago'. All Subset T respondents (6) are still currently receiving treatment with talquetamab.

When asked if they or the person they care for were "*…receiving talquetamab alone, or in combination with another drug? If applicable, please indicate the drug you were/are receiving alongside talquetamab.",* 2 Subset T respondents (6) selected 'Talquetamab alone (as monotherapy)', and 4~~5~~ indicated 'in combination with another drug' and provided the drug name(s). Of these 4~~5~~ patients, 3 are receiving teclistamab in combination with talquetamab, and one is receiving daratumumab and pomalidomide alongside talquetamab.

When asked, "*Were you or the person you care for admitted to the hospital at any point in the initial step- up dosing period? If yes, please indicate how many nights were spent in the hospital.*" 5 of 6 Subset T respondents chose 'Yes' and indicated the length of their stay, while one respondent chose 'No'. The most frequently reported stay length fell between 9 and 10 nights. [All responses: 6 nights (1), 10 nights (2), 9-10 nights (1), 1 and a half weeks (1).]

When asked, "*How often do you visit a hospital/ cancer centre for talquetamab treatment since the step- up dosing period ended?*", 2 Subset T respondents (6) chose 'Once a week', 1 chose 'Every two weeks' and, 3 respondents chose other all of whom commented they received treatment once a month. Of these three, all are receiving talquetamab in combination with teclistamab. Subset T (6) was asked, "*Which of the most frequent talquetamab side effects listed below have you/the person you care for experienced? Please select all that apply and rate the side effects severity on a scale of 1 Not at all bearable to 5 Extremely bearable'.".* By weighted average of responses, 6 respondents rated oral-related (2.33) and nail related issues (2.33) as the least bearable side effects, followed by skin-related issues (2.83), and infections (3.17). Similarly, the median response to all listed side effects was 3 – Somewhat bearable or higher, except for nail, skin, and oral issues (median 2 – Slightly bearable').

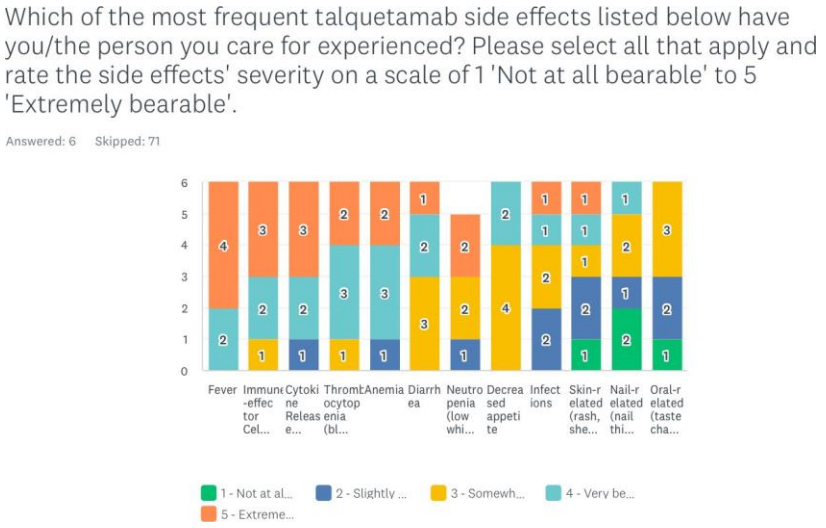

Figure 6 — Experience of talquetamab side effects (Subset T; 6)

When asked "*How effective was the supportive care you received in managing your side effects from talquetamab treatment? Please rate on a scale of 1–5 where 1 is Not at all effective and 5 is Extremely effective", 3* Subset T respondents (6) each chose '4 – Significantly effective' (3) and '3 – Somewhat effective (3)'.

Subset T respondents (6) were asked "*Compared to past treatments you/the person you care for received, do you think talquetamab treatment had any of the following advantages and/or disadvantages?",* and were provided the following list of factors and asked to indicate if they felt there had been an increase or decrease in that area; Treatment side effects (Increased: 3, No change: 0, Decreased: 1, Too soon to tell: 2) Control of myeloma and its symptoms (Increased: 2, No change: 0, Decreased: 2, Too soon to tell: 2); Frequency of trips to the hospital or cancer centre for treatment (Increased: 3, No change: 2, Decreased: 1, Too soon to tell: 0); Tolerability of the treatment's mode of administration (Increased: 3, No change: 3, Decreased: 0, Too soon to tell: 0); and Quality of life (Increased: 1, No change: 2, Decreased: 1, Too soon to tell: 2).

Following the instructions "*Please answer each of the following questions on your overall perception of treatment with talquetamab, by rating them on a scale of 1 – 5, where 1 is Not at all and 5 is Completely'",* Subset T patients (5) responded to the questions:

– "*Did talquetamab treatment improve overall quality of life for you or the person you care for?*" (Completely: 2; Mostly: 4, Somewhat: 1; Not at all: 3).

– "*Were the overall side-effects of talquetamab manageable?* (Mostly: 4, Somewhat: 1)

–*Was talquetamab effective in controlling myeloma for you/the person you care for?* (Completely: 3, Mostly: 1, Somewhat: 1),

– "*Did talquetamab meet your expectations in treating myeloma?*" (Completely: 3, Mostly: 2). Comments provided by one patient indicated it was too soon in their treatment to effectively answer most of these questions.

Subset T (6) was asked to indicate how they were or are accessing talquetamab, 4 respondents indicated 'through a clinical trial (ongoing)', 1 selected 'through compassionate access', and 1 selected 'Other' and provided the comment "*Oncologues".*

Finally, when asked if there was anything else they would like to share about their experience with talquetamab, 5 Subset T patients provided the following comments:

"*I think the covid like symptoms were probably due to my immune system working overtime, because my oncologist was very pleased with the results because bloodwork indicated within a month and half that I was in remission and a bone marrow confirmed remission status at the 3 month stage. I did however still experience many of the side effects especially loss of taste or appetite, difficulty swallowing. I am however extremely grateful for the 3 bonus years I have experienced to date and looking forward to many more as I continue with my 15 year multiple myeloma journey*.";

"I have not been on the drug long enough to have strong opinions but so far it has been fine."

"*life saving but does negatively affect quality of life. Pruritis, loss of taste/smell, immunodepression resulted in chronic resp infection that will probably kill me."*

"*Est-ce cela va toujours être 1 fois semaine*." *"Itching in legs"*

6. Anything Else?

Subset E (32) was posed questions to gauge their awareness and understanding of anti-GPRC5D targeted t-cell engaging therapies. When asked "*Have you heard of G protein–coupled receptor class C group 5 member D (GPRC5D) targeted t-cell engaging therapies to treat myeloma?"* 12 survey respondents chose 'Yes', 8 chose 'Yes, but I'm not sure what they are', 10 respondents chose 'No', and 2 chose 'I'm not sure'. When the 20 respondents with previous awareness were asked where they learned of GPRC5D-targeted T-cell engaging therapies, 11 chose 'Through Myeloma Canada', 7 chose 'Through my own research', 6 chose 'Through my oncologist/care team', 5 chose 'Through another organization…', and 4 chose 'Through my support group/other people with myeloma'. Subset E (32) was then asked to select the correct definition for *G protein–coupled receptor class C group 5 member D targeted (GPRC5D), t-cell engaging, bispecific antibody therapies,* 17 of 32 respondents correctly identified the answer was 'all of the above', and the additional respondents gave a partially correct answer. So, over half surveyed patients and caregivers who would be eligible for talquetamab have thus at least heard of GPRC5D targeted t-cell engaging bispecific antibodies (like talquetamab) for the treatment of multiple myeloma. Though a direct comparison cannot be made, based on results of past Myeloma Canada surveys it does appear that knowledge of GPRC5D-targeted bispecific antibodies is less widespread than knowledge of anti-BCMA targeted bispecific antibodies. A persistent fear for this sub-population of myeloma patients (triple-class exposed, relapsed/refractory, on third line+ of treatment) is the availability of further treatments when their current regimen becomes no longer effective. As a result, many patients and caregivers seek information on new drugs, and even more are exposed to the information in their environment. Considering the relatively greater number of BCMA-targeted therapies for myeloma currently available (in Canada and beyond), it follows that there is less information about GPRC5D targeted therapies in their environment, and/or the available information is less salient.

Myeloma Canada has recently conducted two different surveys about bispecific antibody therapies under review by the pERC, both surveys gathered more responses from those who had experience with the drug under review, and a greater proportion of these respondents were receiving the drug under review as a monotherapy. This may or may not

indicate lower uptake of talquetamab, but it does complicate interpretation of survey results, particularly regarding side effects. Similarly, it has been noted in the literature that side-effects can be mitigated to some extent by reductions in dose and frequency of treatment, only two patients were receiving talquetamab at a Q1 frequency.

It was notable that cytokine release syndrome (CRS) and immune-effector cell associated neurotoxicity syndrome (ICANS), despite causing significant concern for Subset E (least tolerable side effects; weighted average rating 2.19), were considered the second and third most bearable side effect for Subset T patients and caregiver who had personal experience with talquetamab (weighted average ICANS: 4.33; CRS: 4.17), and only one side effect 'Fever' received more ratings of '5– Extremely bearable' (3 each) from Subset T. For CRS specifically, this pattern has been seen across all recent treatment surveys conducted by Myeloma Canada in which CRS was a side effect of the drug under review (ex. teclistamab, elranatamab, ciltacabtagene autoleucel). This is indicative of a need for better patient education regarding CRS, though when presented with data showing the low severity of CRS in patients from the *MonumenTAL-1/2* trial (page 6), Subset E's responses indicated this information was not particularly reassuring for most respondents.

The data (though limited) show there are some Canadian doctors currently prescribing talquetamab to their patients, though largely in urban areas. Thus, increased consideration must be given to rural/remote patients, ensuring there is equal access to talquetamab both across and *within* provinces.

Table 1: Financial Disclosures

Check Appropriate Dollar Range With an X. Add additional rows if necessary.

Company	$0 to 5,000	$5,001 to 10,000	$10,001 to 50,000	In Excess of $50,000
Abbvie		☒	☒	☒
AstraZeneca		☐	☒	☐
Apotex		☐	☐	☒
Amgen		☐	☐	☒
The Binding Site		☐	☐	☒
BMS		☐	☐	☒
FORUS Therapeutics		☐	☐	☒
GSK		☐	☐	☒
IMC		☒	☐	☒
JAMP		☐	☒	☐
Janssen		☐	☐	☒
Merck		☐	☒	☐
Pfizer		☐	☐	☒
Rapid Novor		☐	☐	☒
Roche		☐	☒	☐
Sanofi		☐	☐	☒
Sebia Diagnostics		☐	☒	☐
Takeda		☐	☒	☐

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: Aidan Robertson
Position: Advisor, Health Policy and Advocacy
Patient Group: Myeloma Canada
Date: May 13 2024

Clinician Group Input

CADTH Project Number: PC0363

Generic Drug Name (Brand Name): talquetamab

Indication: For the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least three prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent and an anti-CD38 monoclonal antibody, and have demonstrated disease progression on or after the last therapy.

Name of Clinician Group: OH (CCO) Hematology Cancer Drug Advisory Committee

Author of Submission: Dr. Tom Kouroukis

1. About Your Clinician Group

OH(CCO)'s Drug Advisory Committees provide timely evidence-based clinical and health system guidance on drug-related issues in support of CCO's mandate, including the Provincial Drug Reimbursement Programs (PDRP) and the Systemic Treatment Program.

2. Information Gathering

Information was gathered via videoconferencing.

3. Current Treatments and Treatment Goals

Current treatments include Pd, Kd, SVd, chemotherapy, CAR-T (not yet funded), bispecific antibodies (not yet funded), and clinical trials.

Goals are to prolong life, delay progression, improve symptoms and quality of life.

4. Treatment Gaps (unmet needs)

4.1. Considering the treatment goals in Section 3, please describe goals (needs) that are not being met by currently available treatments.

Other than Car-T cell therapy and bispecific antibodies such as teclistamab and elranatamab, there is no other substantial treatment available for triple class exposed patients.

With talquetamab, there is ease of administration (subcutaneous injection, no need for apheresis) and a different target than other bispecific antibodies.

5. Place in Therapy

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

This is another option for triple class exposed patients, most likely to be used in third and fourth line. This may be helpful in previously anti-BCMA exposed patients.

This can also be used as a bridge to CAR-T cell therapy.

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?

As per clinical trial.

5.3 What outcomes are used to determine whether a patient is responding to treatment in clinical practice? How often should treatment response be assessed?

Standard myeloma response measures as well as CRS and ICANS toxicity grading scales.

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

Loss of response, progression, significant toxicities.

5.5 What settings are appropriate for treatment with [drug under review]? Is a specialist required to diagnose, treat, and monitor patients who might receive [drug under review]?

Centers skilled in managing CRS and ICANS, with availability of tocilizumab. There may be some inpatient component required for monitoring purposes and for drug administration.

6. Additional Information

Non-secretory patients with myeloma should also be eligible.

7. Conflict of Interest Declarations

To maintain the objectivity and credibility of the CADTH drug review programs, all participants in the drug review processes must disclose any real, potential, or perceived conflicts of interest. This conflict of interest declaration is required for participation. Declarations made do not negate or preclude the use of the clinician group input. CADTH may contact your group with further questions, as needed. Please see the *Procedures for CADTH Drug Reimbursement Reviews* (section 6.3) for further details.

1. Did you receive help from outside your clinician group to complete this submission? If yes, please detail the help and who provided it.

   OH(CCO) provided a secretariat function to the group.

2. Did you receive help from outside your clinician group to collect or analyze any information used in this submission? If yes, please detail the help and who provided it.

   No.

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

Declaration for Clinician 1

Name: Dr. Tom Kouroukis
Position: OH (CCO) Hematology Cancer Drug Advisory Committee lead
Date: 11-04-2024

☒ **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. Selay Lam
Position: OH (CCO) Hematology Cancer Drug Advisory Committee member
Date: 11-04-2024

☒ 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**
Janssen	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 3

Name: Dr. Jordan Herst
Position: OH (CCO) Hematology Cancer Drug Advisory Committee member
Date: 11-04-2024

☒ 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**
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 4

Name: Dr. Pierre Villeneuve
Position: OH (CCO) Hematology Cancer Drug Advisory Committee member
Date: 11-04-2024

☒ 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

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

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

Declaration for Clinician 5

Name: Dr. Joanna Graczyk
Position: OH (CCO) Hematology Cancer Drug Advisory Committee member
Date: 11-04-2024

☒ 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

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

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

Declaration for Clinician 6

Name: Dr. Lee Mozessohn
Position: OH (CCO) Hematology Cancer Drug Advisory Committee member
Date: 11-04-2024

☒ 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 6

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

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

Declaration for Clinician 7

Name: Rami El-Sharkaway
Position: OH (CCO) Hematology Cancer Drug Advisory Committee member
Date: 11-04-2024

☒ 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 7

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

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

CADTH Project Number: PC0363-000
Generic Drug Name (Brand Name): Talquetamab
Indication: Relapsed or refractory multiple myeloma
Name of Clinician Group: The Canadian Myeloma Research Group
Author of Submission: Dr. Arleigh McCurdy

1. About Your Clinician Group

The Canadian Myeloma Research Group (CMRG) is a Canada-wide network of researchers aiming to develop better treatments for extending life of patient with multiple myeloma, enhancing the quality of life for those living with myeloma and related diseases, and working to find a cure for these diseases and other plasma cell disorders. The three main purposes of CMRG are: 1) conducting investigator-initiated academic clinical trials to improve the outcome of myeloma patients; 2) maintenance of a national Myeloma Database, now consisting of over 10 000 Canadian patients, to evaluate real-word patterns of treatment, outcomes, risk factors, and areas for future research in myeloma; and 3) generation of consensus statements for myeloma management.

Website: cmrg.ca

2. Information Gathering

CMRG holds monthly physician teleconferences, and participants agreed to submit a single document for feedback to CADTH which would be signed by the physicians who agreed with the information. The initial draft of the document was prepared in consultation with the CMRG Chief Medical Officer and sent to all members to obtain input. Comments and suggestions were incorporated as appropriate. The final draft was signed by physicians who agreed with all of the content and their Conflict of Interest obtained as required.

3. Current Treatments and Treatment Goals

- The overall treatment goals are to: 1) control the disease and its associated sequalae (bone destruction/pain, renal failure, hypercalcemia, low blood counts) by achieving an anti-myeloma response; 2) maintain control of myeloma and its manifestations for as long as possible given the current incurable nature of the disease (i.e. maximize progression-free survival); 3) Improve overall survival; 4) minimize adverse effects of treatment; and

5) optimize QOL by adequately controlling the disease and minimizing toxicity with the aim to tailor the treatment approach to the individual patient.

- Initial Therapy: Newly diagnosed Canadian myeloma patients are currently divided into those who are transplant-eligible (TE), or transplant-ineligible (TI) based on age and fitness. TE patients receive induction with RVD followed by high-dose melphalan + ASCT followed by lenalidomide maintenance until disease progression. TI patients have previously most often received Rd or RVd followed by single-agent lenalidomide (also given until disease progression); more recently daratumumab-based combinations such as DRd are standard. Support for these algorithms comes from published phase 3 trials as well as real-world CMRG analyses. These approaches have also been endorsed by CADTH in the Provisional Funding Algorithm.
- Second-line therapy (after 1 prior regimen): Second-line therapy depends on whether patients have progressed on lenalidomide (currently this includes most ASCT and TI patients). Key in second-line therapy is the inclusion

of an anti-CD38 antibody such as daratumumab or isatuximab (if not received in first line) which represents a high-priority for virtually all patients. Isatuximab is now reimbursed in most provinces in combination with carfilzomib and dexamethasone (IsaKd), with many patients now being with this IsaKd after 1-3 prior lines.
Daratumumab is reimbursed in the relapsed setting for patients relapsing after 1-3 prior lines of therapy as well, with some patients receive daratumumab, bortezomib and dexamethasone (DVd) as second-line therapy. The minority of patients who did not progress on a lenalidomide-containing first-line therapy have been preferentially treated with DRd.

- Other relevant anti-CD38 monoclonal antibody-containing regimens have been approved by Health Canada and could be used in second line. Ideally, such patients would receive daratumumab/isatuximab with dexamethasone and POM (DPd, IsaPd), or daratumumab/Isatuximab with dexamethasone and carfilzomib (DKd). (Presently, only the isatuximab-containing regimens are approved and **funded** in Canada and are incorporated into the recent CADTH funding algorithm).
- As more TI patients progress after anti-CD38 containing regimens as initial therapy, current second-line therapy is based on combinations of either proteasome inhibitors (bortezomib or carfilzomib) **or** pomalidomide [POM]. Funded options include bortezomib + dex +/- cyclophosphamide [Vd or CyBorD], selinexor + bortezomib + dex (SVd), carfilzomib + dex +/- cyclophosphamide [Kd or KCd] and POM + dex +/- cyclophosphamide [PCd]. However, provincially funded regimens often restrict access to POM-based therapy in second line and require exposure to both a PI and lenalidomide first. Triplet regimens are generally preferable to doublets. Of note, there are currently no publicly reimbursed or compassionate access to any BCMA-targeted agents in patients with 1-2 prior lines of treatment.
- Third-line therapy (after 2 prior regimens): If patients have not yet received an anti-CD38 monoclonal antibody by the time of third-line treatment is needed, every effort is made to procure a combination containing such agents. Otherwise, third-line therapy is usually based on either POM or carfilzomib with less efficacious partners. Funded options include POM + dex +/- cyclophosphamide (PCd) or carfilzomib + dex +/- cyclophosphamide (Kd or KCd). Patients who remain bortezomib-sensitive can be retreated with it. As above, SVd is also an option. Again, triplet regimens are generally preferable.
- Fourth-line therapy: Options are limited. A POM- or carfilzomib-based regimen such as Pd or Kd may be utilized if not used earlier in the third line. Bortezomib-based regimens can be explored but only if patients are still PI-sensitive which is rare by fourth line.. As such, palliation/best supportive care/local radiotherapy are often all that can be pursued.
- While antibody drug conjugates, bispecific antibodies and cellular therapy are positioned to fill this triple class refractory space, none are currently reimbursed in Canada.
- Cilta-cel has been endorsed by CADTH but at present negotiations are ongoing to establish provincial pricing. Even once this is achieved, we expect ongoing bottlenecks due to production limitations and challenges with capacity at the institutional level.
- Teclistamab has been endorsed by CADTH but at present negotiations are ongoing to establish provincial pricing.
- Elranatamab is currently undergoing CADTH review.
- There are currently compassionate patient support programs open for Teclistamab and Elranatamab, the duration of which are unknown. Not all institutions are able to support/treat patients receiving compassionate drug.
- Clinical trials are key to improving survival of Canadian patients through early access to promising agents in this setting but access is markedly limited by: 1) strict eligibility criteria, such as the need for good hematologic reserve and adequate renal function, may be challenging to meet in advanced myeloma; 2) the decision by pharma to open promising trials in only a few Canadian sites; 3) the policy of pharma to offer a time-limited trial spot for only few days, so if a patient is not available immediately, the opening is removed and given to a centre in another country; 4) slow trial accrual to promising agents in a phase 1 study as DSMB reviews need to take place before a new cohort can be opened.

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.

Myeloma remains incurable and patients eventually become refractory to all available agents. The highest unmet need in myeloma is patients with advanced disease who have received multiple lines of treatment and have already received the three major classes of drugs ("triple-class exposed/refractory") including an IMID, PI and anti-CD38 monoclonal antibody. Outcomes in this patient population are dismal in the Canadian landscape due at least partly to the lack of access to additional novel agents, including bispecific antibodies and car-T therapy. This is supported by data from our CMRG group examining outcomes in these triple-class refractory patients. The ORR to subsequent line of treatment was approximately 40% with the median PFS from start of subsequent therapy being 4.4 months, and the median OS being 10.5 (95% CI 8.5-13.8) months (LeBlanc, R et al. 2023; *Eur J Haematol* and Visram A, et al. American Society of Hematology Annual Meeting, 2022). The clinical features associated with advanced disease and short duration of responses lead to a poor quality of life, significant caregiver burden and a shortened patient lifespan. Thus, this situation represents one of the most pressing unmet needs in Canada for patients with multiple myeloma.

5. Place in Therapy

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

Bispecific and CAR-T cell therapies are presently positioned to address the unmet need in the "triple-class exposed/refractory" myeloma patients. Several BCMA directed agents have recently been endorsed as mentioned, including cilta-cel and teclistamab, with elranatamab under review.

Talquetamab is the first approved therapeutic in myeloma to target G-protein-coupled receptor class C group 5 member D (GPRC5D). As such, this bispecific antibody represents a new therapeutic against a novel target, potentially overcoming resistance mechanisms to the more traditional approved approaches and the newer BCMA-directed treatments.

Currently, it would be used in sequence after the other lines of therapy described in Section 3., per the available information from CADTH. Like the recently endorsed products cilta-cel and teclistamab, the latest data for talquetamab are expected to exceed that of any previous standard of care regimen for this group of "triple-class refractory" patients.

As there are very few options in patients with triple-class refractory disease, the issue of intolerance to other treatments or contraindications to other treatments is less relevant. Specifically, all other options that are currently available in this setting yield markedly inferior results.

As talquetamab will be used late in the current lines of myeloma treatment, i.e. after failure of multiple agents, it is not expected to impact the sequencing of agents earlier in the disease course or lead to a major change in treatment algorithms prior to patients becoming "triple-class exposed/refractory". However, like the other novel immunotherapeutics, given its efficacy in terms of both a high response rate and durability of response, it is expected to lead to a major shift in the current treatment paradigm for those with advanced disease.

It will provide an additional, more readily accessible T-cell redirecting therapy for patients refractory to the most used agents. Availability of talquetamab will complement access to the recently endorsed T-cell redirecting therapies (cilta-cel T-cell and teclistamab), broadening access to such new therapeutic strategies, and ensuring that logistical bottlenecks do not become a barrier for delivery of these novel products to Canadian patients.

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 least suitable patients would include frail patients with poor functional status and organ reserve. Patients receiving T-cell redirecting therapies should have the fitness to contend with the initial treatment period, which include the risks of CRS and ICANS. Additionally, those with rapidly proliferating disease, ongoing infection, significant organ dysfunction

and/or with pre-existing pancytopenia represent challenging clinical situations, although it should be noted that talquetamab does not require the lengthy preparation time inherent in the generation of CAR-T cells.

Conversely, patients with a good performance status, minimal or no comorbidities, relatively low tumor burden, adequate organ function and satisfactory blood counts are the most likely to have the best outcomes. It is, however, important to note that the rates of immune-related complications are lower with bispecific antibodies in general-making them more broadly applicable to patients and more amenable to patients with more comorbidities (be they disease- related or otherwise). Moreover, they represent an “off the shelf” treatment which can be administered quickly even in the face of rapidly proliferative myeloma. Chronological older age alone *per se* does not seem to be an exclusion factor. Overall, patients with poor disease-related prognostic factors, such as extramedullary myeloma and high-risk cytogenetics, do not fare significantly worse and should be eligible for talquetamab.

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?

Responses are based on the monoclonal protein markers in the serum and/or urine, bone marrow biopsy and, in some instances, by imaging studies (standardized International Myeloma Working Group Criteria (IMWG)). These parameters are aligned with those used in the clinical trials, which also included the emerging parameter of marrow minimal residual disease (MRD).

Clinically meaningful responses usually correlate with at least a partial remission by IMWG Consensus Criteria. These include improvement in symptoms (cessation of bone destruction with less pain, fractures and need for radiotherapy), improvement in energy and better ability to perform activities of daily living. In myeloma, responses are generally assessed every 1-3 months depending on clinical stability and regimen used for therapy.

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

Like more conventional myeloma therapies, talquetamab is presently given until disease progression. Treatment is continued based on ongoing efficacy, as measured above, and long-term tolerability is required. Other side effects of note include skin toxicity (xeroderma, pruritis, peeling), nail changes, dysgeusia, and infections. While supportive care paradigms are evolving to mitigate these complications, recurrent or life-threatening complications despite maximal supportive care may require a cessation of therapy despite disease control.

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]?

We recommend that talquetamab be administered and monitored by hematologists/oncologists who have the knowledge and expertise to manage the potential short- and long-term adverse events that can be associated its use. We also recommend administration of the initial dosing in centers with, or the commitment to develop, the necessary infrastructure, experience and supports to safely administer T-cell redirecting therapies, for example, clinical assessment tools for CRS/ICANS grading/treatment, ICU support, and ready tocilizumab availability.

6. Additional Information

Two other points are worth considering with respect to implementation:

1) Presently, the focus on number of lines of therapy--in addition to the actual classes of prior agents received--are both included in the indication. We feel this may be too restrictive, especially with the widespread use of triplet-containing regimens including both a PI and an IMID for frontline induction therapy pre-ASCT and the much earlier use of anti-CD38-containing regimens. Both the Canadian RWE as well as results published by others indicates the triple-class exposure/refractoriness, regardless of the numerical line of therapy, confers a poor outcome. The field of myeloma is moving away from the "lines of therapy" concept as a reliable measure of disease resistance, in order to avoid giving patients ineffective regimens to meet a target number of combinations. An important recent recommendation from another expert group has suggested that "refractoriness to drugs/drug classes is a more consistent/scientific definition of prior therapies as compared to prior lines" (Goel U, et al. *Blood Cancer J* 2023; 13:11).

Therefore, we feel that the final indication for talquetamab should exclude the "requirement of 3 prior lines of therapy" and focus on the specific previous agents received. We would propose the following: **Talquetamab is indicated for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least three prior therapies, including a proteasome inhibitor, an immunomodulatory agent and an anti-CD38 monoclonal antibody, and who have demonstrated disease progression after the last therapy.**

2) One other consideration in developing the implementation strategy is to address usage of talquetamab in patients who have previously received prior T-cell redirecting therapies. In the Canadian landscape, this currently includes anti-BCMA therapy, including bispecific antibodies and car-t therapy. Evidence to date suggests responses to talquetamab are maintained even in patients who received prior ant-BCMA therapy (*Jakubowiak et al Blood [suppl 1, 2023 p. 3377], O Ven Oekelen et al, Blood 141(7) 2023, p. 756-765)*

Given that prior anti-BCMA exposure does not preclude responsiveness to talquetamab, we would recommend that patients with prior anti-BCMA therapy/bispecific antibody treatment be allowed access to talquetamab.

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.

<Enter Response Here>

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.

<Enter Response Here>

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.**

3) Declaration for Clinician 1

4) **Name: Dr. Arleigh McCurdy**
Position: Hematologist/Oncologist, Ottawa
5) **Date: 13/05/2024**

☒ **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.

6) **Table 1: Conflict of Interest Declaration for Clinician 1**

Company	Check appropriate dollar range*			
	$0 to $5,000	$5,001 to $10,000	$10,001 to $50,000	In excess of $50,000
Janssen		X		
Sanofi	X			
GSK	X			
Pfizer	X			
Forus	X			
Amgen	X			

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

7) **Declaration for Clinician 2**

Name: Dr. Sathish Kumar Gopalakrishnan
Position: Hematologist/Oncologist, Sudbury
Date:13-05-2024

☒ 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.

8) **Table 2: Conflict of Interest Declaration for Clinician 2**

Company	Check appropriate dollar range*			
	$0 to $5,000	$5,001 to $10,000	$10,001 to $50,000	In excess of $50,000
Nothing to Declare				
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: Dr. Darrell White
Position: Hematologist, Dalhousie University and QEII Health Sciences Centre Date:
13-05-2024

☒ 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.

9) **Table 3: Conflict of Interest Declaration for Clinician 3**

Company	Check appropriate dollar range*			
	$0 to $5,000	$5,001 to $10,000	$10,001 to $50,000	In excess of $50,000
BMS		X		
Janssen			X	

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

10) **Declaration for Clinician 4**

Name: Dr. Donna Reece
Position: Hematologist/Oncologist, Toronto
Date: 13-05-2024

☒ 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.

11) **Table 4: Conflict of Interest Declaration for Clinician 4**

Company	Check appropriate dollar range*			
	$0 to $5,000	$5,001 to $10,000	$10,001 to $50,000	In excess of $50,000
BMS/ Celgene			X	
Janssen			X	
Amgen			X	
Sanofi	X			
GSK	X			
Takeda	X			

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

Declaration for Clinician 5

Name: Dr. Alfredo de la Torre
Position: Hematologist/Oncologist
Date: 13-05-2024

☒ 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.

12) **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**
Nothing to Declare				
Add company name				
Add or remove rows as required				

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

13) **Declaration for Clinician 6**

Name: Dr. Bethany E. Monteith
Position: Hematologist, Kingston Health Sciences Center
Date: 13-05-2024

☒ **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.

14) **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**
Janssen				x
Honoraria				x
Sanofi				x
Pfizer				x

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

Declaration for Clinician 7

Name: Dr. Anthony Reiman
Position: Professor, Department of Oncology, Saint John Regional Hospital
Date: 13-05-2024

☒ 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.

15) **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**
Nothing to Declare				

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

16) **Declaration for Clinician 8**

Name: Dr. Julie Stakiw
Position: Oncologist Date:
13-05-2024

☒ 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.

17) **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**
Sanofi	X			
Janssen	X			
BMS	X			
Forus	X			
Pfizer	X			
Beigene	X			

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

18) **Declaration for Clinician 9**

Name: Dr. Christopher Venner
Position: Hematologist/Oncologist, Vancouver Centre
Date: 13-05-2024

☒ 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.

19) **Table 9: Conflict of Interest Declaration for Clinician 9**

Company	Check appropriate dollar range*			
	$0 to $5,000	$5,001 to $10,000	$10,001 to $50,000	In excess of $50,000
Celgene/BMS	X			
Takeda	X			
Janssen	X			
Amgen	X			
Sanofi	X			
GSK	X			

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

20) **Declaration for Clinician 10**

Name: Dr. Richard LeBlanc
Position: Hematologist/Oncologist, Montreal

21) **Date: 13-05-2024**

☒ **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.

22) **Table 10: Conflict of Interest Declaration for Clinician 10**

Company	Check appropriate dollar range*			
	$0 to $5,000	$5,001 to $10,000	$10,001 to $50,000	In excess of $50,000
Janssen – advisory boards and honoraria			X	
Pfizer – advisory board and honoraria		X		
Amgen – advisory boards	X			
Sanofi – advisory boards	X			
FORUS Therapeutics – advisory boards	X			

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

23) **Declaration for Clinician 11**

Name: Dr. Nicole Laferriere

Position: Hematologist/Oncologist, Thunder Bay
Date: 13-05-2024

☒ 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.

24) **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**
Nothing to Declare				

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

25) **Declaration for Clinician 12**

Name: Dr. Sindu Kanjeekal
Position: Hematologist/Oncologist, Windsor
Date: 13-05-2024

☒ 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.

26) **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**
Nothing to Declare				

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

27) **Declaration for Clinician 13**

Name: Dr. Ibraheem Othman
Position: Hematologist/Oncologist, Regina
Date: 13-05-2024

☒ 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.

28) **Table 13: Conflict of Interest Declaration for Clinician 13**

Company	**Check appropriate dollar range***

	$0 to $5,000	$5,001 to $10,000	$10,001 to $50,000	In excess of $50,000
Nothing to Declare				

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

29) **Declaration for Clinician 14**

Name: Dr. Suzanne Trudel
Position: Oncologist
Date: 13-05-2024

☒ 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.

30) **Table 14: Conflict of Interest Declaration for Clinician 14**

	Check appropriate dollar range*			
Company	$0 to $5,000	$5,001 to $10,000	$10,001 to $50,000	In excess of $50,000
Sanofi	X			
BMS			X	

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

31) **Declaration for Clinician 15**

Name: Dr. Sita Bhella
Position: Hematologist/Oncologist, Toronto
Date: 13-05-2024

☒ 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.

32) **Table 15: Conflict of Interest Declaration for Clinician 15**

	Check appropriate dollar range*			
Company	$0 to $5,000	$5,001 to $10,000	$10,001 to $50,000	In excess of $50,000
Gilead	X			
Novartis	X			
Sanofi	X			
Amgen	X			
Celgene/Bristol Myers Squibb	X			

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

Declaration for Clinician 16
Name: Martha L Louzada **Position:** Hematologist, London **Date:** 13-05-2024

☒ **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.

33) **Table 16: Conflict of Interest Declaration for Clinician 16**

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

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

34) **Declaration for Clinician 17**

Name: Dr. Rami Kotb
Position: Hematologist/Oncologist, Winnipeg
Date: 13-04-2024

☒ 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.

35) **Table 17: Conflict of Interest Declaration for Clinician 17**

	Check appropriate dollar range*			
Company	**$0 to $5,000**	**$5,001 to $10,000**	**$10,001 to $50,000**	**In excess of $50,000**
BMS, Amgen, JNJ		X		
Takeda	X			
Sanofi, Merck				X
Karyopharm				X

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

36) **Declaration for Clinician 18**

Name: Dr. Nizar Abdel Samad
Position: Hematologist/Oncologist, Moncton Date: 13-05-2024

☒ 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.

37) **Table 18: Conflict of Interest Declaration for Clinician 18**

	Check appropriate dollar range*			
Company	**$0 to $5,000**	**$5,001 to $10,000**	**$10,001 to $50,000**	**In excess of $50,000**
Nothing to Declare				

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

38) **Declaration for Clinician 19**

Name: Dr. Jean Roy
Position: Hematologist/Oncologist, Montreal Date:
13-05-2024

☒ 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.

39) **Table 19: Conflict of Interest Declaration for Clinician 19**

	Check appropriate dollar range*			
Company	**$0 to $5,000**	**$5,001 to $10,000**	**$10,001 to $50,000**	**In excess of $50,000**
Nothing to declare				

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

40) **Declaration for Clinician 20**

Name: Dr. Kevin Song
Position: Hematologist/Oncologist, Vancouver
Date: 13-05-2024

☒ 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.

41) **Table 20: Conflict of Interest Declaration for Clinician 20**

	Check appropriate dollar range*			
Company	**$0 to $5,000**	**$5,001 to $10,000**	**$10,001 to $50,000**	**In excess of $50,000**
Bristol Myers Squibb		X		

Janssen		X		
Amgen		X		

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

42) **Declaration for Clinician 21**

Name: Dr. Stephen Parkin
Position: Hematologist/Oncologist, Vancouver Date:
08-09-2023

☒ 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.

43) **Table 21: Conflict of Interest Declaration for Clinician 21**

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

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

44) **Declaration for Clinician 22**

Name: Dr. Guido Lancman
Position: Hematologist/Oncologist, Toronto
Date: 13- 05-2024

☒ 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.

45) **Table 22: Conflict of Interest Declaration for Clinician 22**

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

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

46) **Declaration for Clinician 23**

Name: Dr. Alissa Visram
Position: Hematologist/Oncologist, Ottawa
Date: 13-05-2024

☒ 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.

47) **Table 23: Conflict of Interest Declaration for Clinician 23**

Company	Check appropriate dollar range*			
	$0 to $5,000	$5,001 to $10,000	$10,001 to $50,000	In excess of $50,000
Janssen	X			
Pfizer	X			

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

48) **Declaration for Clinician 24**

Name: Dr. Christopher Cipkar
Position: Hematologist/Oncologist, Ottawa
Date: 13-05-2024

☒ 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.

49) **Table 24: Conflict of Interest Declaration for Clinician 24**

Company	Check appropriate dollar range*			
	$0 to $5,000	$5,001 to $10,000	$10,001 to $50,000	In excess of $50,000
Nothing to Declare				

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

50) **Declaration for Clinician 25**

Name: Dr. Christine Chen
Position: Hematologist, Princess Margaret Cancer Centre Date:
13-05-2024

☒ 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 25: Conflict of Interest Declaration for Clinician 25

	Check appropriate dollar range*			
Company	**$0 to $5,000**	**$5,001 to $10,000**	**$10,001 to $50,000**	**In excess of $50,000**
Janssen			X	
Beigene	X			
AstraZeneca	X			
Gilead	X			
Novartis	X			