Clinician Input Template for CADTH pan-Canadian Oncology Drug Review Program

*Before completing this template, be sure to* [*register*](https://drugreviewsadmin.cadth.ca/Landing/Register/Register.aspx?Lang=EN) *with the pCODR program. Please visit* [*www.cadth.ca/pcodr/registration*](http://www.cadth.ca/pcodr/registration) *for information about the registration process.*

1. **About the Registered Clinician**

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| Name of Registered Clinician |  |
| Title |  |
| Disease Specialty (if applicable) |  |
| Province |  |
| Organization Membership (if applicable, national or provincial) |  |
| Email |  |
| Telephone Number |  |

If this is a joint clinician input submission, please indicate the organization this submission is on behalf of, as well as list the names of the other clinicians and disease site specialty (if applicable). Please note that all clinicians listed must also register with CADTH and complete conflict of interest declaration forms.

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**Confirmation of Authorship**

I declare that I am the author of this submission and I confirm that no other parties have written or participated in the writing of the submission, except for those abovenamed in this joint submission (if applicable).

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| Signature |  | Date (YYYY/MM/DD) |

1. **About the Drug and Indication Under Review**

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| CADTH pCODR Project Number | pCODR 10207 |
| Generic Drug Name (Brand Name) | Glasdegib (Daurismo) |
| Indication | Acute Myeloid Leukemia |
| Funding Request | In combination with low-dose cytarabine, for the treatment of adult patients with previously untreated acute myeloid leukemia (AML) |
| Trial(s) Being Submitted to pCODRa | BRIGHT AML 1003 ([NCT01546038](https://clinicaltrials.gov/ct2/show/NCT01546038)) |
| Health Canada Status | Pending approval |
| FDA | [November 2018](https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/210656s000lbl.pdf)In combination with low-dose cytarabine, for the treatment of newly-diagnosed acute myeloid leukemia (AML) in adult patients who are ≥75 years old or who have comorbidities that preclude use of intensive induction chemotherapy. |
| European Medicines Agency Status | Pending approval |
| Practice Guidelinesa | AML - Version 2.2020, NCCN Clinical Practice Guidelines in Oncology. <https://www.nccn.org/professionals/physician_gls/pdf/aml.pdf> |
| Provincial Funding of Current Treatments or Funding Algorithm | For newly diagnosed AML: intensive, induction chemotherapy with daunorubicin (or idarubicin) and cytarabine followed by consolidation with high-dose cytarabine and possibly hematopoietic stem cell transplant. For patients who are not eligible for this treatment, options include less intensive chemotherapy regimens (e.g. low-dose cytarabine [LDAC], azacitidine, decitabine) or best supportive care. Some types of AML can be treated with targeted agents. |

a Please note that access to some online publications require subscription.

1. **Key Questions for Clinician Input**

## 3.1 Current Treatment(s) for the Indication Under Review:

* If this is different than what is listed in the Provincial Funding of Current Treatments or Funding Algorithm on the previous page, identify the treatment(s) you would use.
* If more than one treatment is funded in your province, identify the treatment(s) that would be the most appropriate comparator for the drug under review.

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## 3.2 Eligible Patient Population

Describe the patients for whom you would use the new treatment. Examples can include, but are not limited to, the following questions:

* Does the patient population in the reimbursement request align with the need identified in your clinical practice? Is there an unmet need?
* Can the inclusion and exclusion criteria of the clinical trial be applied in clinical practice?
* Is there a subgroup of patients beyond the study population that you would like to use the new treatment in? Is there a subgroup of patients within the study population that the new treatment should be limited to?

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## IMPLEMENTATION QUESTION: Are the criteria used in the trial to identify patients not suitable for intensive chemotherapy reflective of the criteria used for your patients?

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## 3.3 Relevance to Clinical Practice

Do you have experience with using the treatment (through clinical trials, manufacturer’s access program, private drug insurance) under review?

[ ] Yes [ ] No

* How or when would you use the new treatment? Is there any population/subpopulation where you particularly want to use this drug?
* How is the new treatment different than currently available treatments with respect to efficacy, safety, and tolerability?
* Are there contraindications to using the new treatment? Are there contraindications to current treatments that would make the new treatment favourable?

Please note: Scientific published references are not required, as pCODR has access to current scientific literature through the manufacturer’s submission and a rigorous, independent literature search.

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##  3.4 Sequencing and Priority of Treatments

* Please describe how the new treatment could be sequenced with current treatment(s), if appropriate.
* In your opinion, in the event that the drug under review becomes available for funding in your jurisdiction, would the new treatment be a replacement of current treatment(s) or another option?

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 **IMPLEMENTATION QUESTIONS**

* **What would be the preferred sequencing of therapies for patients with an identified mutation?**

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* **Is there any evidence that specific subtypes of AML (e.g., based on cytogenetics, therapy-related AML) or subgroups of patients should not receive glasdegib?**

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* **What treatments would be given to patients upon progression of glasdegib+LDAC?**

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* **Is there any comparative data that would inform selection of either azacitidine or glasdegib+LDAC as the preferred regimen?**

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* **Is there any evidence to inform whether glasdegib plus low-dose cytarabine could be used as an additional line of therapy in patients who have either experienced disease progression on intensive?**

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## 3.5 Companion Diagnostic Testing

* If companion diagnostic testing is required for the new drug, is the test available in your jurisdiction? Is it funded by your jurisdiction? What concerns, if any, do you have on the test and turnaround time for test results? Are there specific considerations to a testing algorithm that you think would be important to share with the pCODR Expert Review Committee?

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1. **Implementation Questions**

The Ministries of Health and provincial cancer programs across Canada are concerned about the sustainability of high-quality cancer control services. The rising cost of cancer drugs is becoming a major challenge to the sustainability of cancer care funding. While tremendous progress has been made in recent years in the cancer drug system, more is needed to be done to ensure innovative treatments are available to patients, while ensuring value for money for the public.

We are seeking your clinical opinion on the following implementation issues, if and when the new treatment is reimbursed. Your responses would be taken into consideration, among other factors, when Ministries of Health and provincial cancer programs make their final funding decisions.

**4.1. Would it be appropriate to implement a modified low-dose cytarabine regimen to account for clinic opening hours?**

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**Appendix A: pCODR Clinician Conflict of Interest Declarations**

**Please note: Each registered clinician must complete their own separate pCODR Clinician Conflict of Interest Declarations Template even if the submission is made jointly.**

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| **Name of registered clinician:** |  |
| **Name of drug and indication under review:** |  |

**Conflict of Interest Declaration**

To maintain the objectivity and credibility of the pCODR process, all participants in the pCODR review process must disclose any conflicts of interest. A registered clinician must declare any potential conflicts of interest that may influence or have the appearance of influencing the information submitted. A conflict of interest declaration is requested for transparency — it does not negate or preclude the use of the clinician input.

Examples of conflicts of interest include, but are not limited to:

* financial support from the pharmaceutical industry or other entities (e.g., educational or research grants, honoraria, gifts, and salary)
* affiliations, or personal or commercial relationships with drug manufacturers or other interest groups.

**Section A: Payment Received**

1. Have you received any payments over the previous two years from any company or organization that may have a direct or indirect interest in the drug under review?

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|[ ]  Yes |
|[ ]  No |

 If no, please go to Section B.

1. What form of payment did you receive? (Check all that apply.)

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|[ ]  Advisory role (e.g., advisory boards, health technology assessment submission advice)  |[ ]  Program or Operating Funding (e.g., website)  |  |
|[ ]  Conference attendance  |[ ]  Research/educational grants  |  |
|[ ]  Royalties |[ ]  Travel grants |  |
|[ ]  Gifts  |[ ]  Sponsorship of events |  |
|[ ]  Honoraria |[ ]  Other, please specify:  |  |

1. Please provide the names of companies and organizations, and the amounts of the payments, in the following table.

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| **Company** | **Nature or description of activities or interests** | **Check Appropriate Dollar Range** |
| **$0 to 5,000** | **$5,001 to 10,000** | **$10,001 to 50,000** | **In Excess of $50,000** |
|  |  | [ ]  | [ ]  | [ ]  | [ ]  |
|  |  | [ ]  | [ ]  | [ ]  | [ ]  |
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**Section B: Holdings or Other Interests**

Have you received or are in possession of stocks or options of more than $10,000 (excluding mutual funds) for organizations that may have a direct or indirect interest in the drug under review? If yes, please list them in the following box.

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**Section C: Affiliations, Personal or Commercial Relationships**

Do you have personal or commercial relationships either with a drug or health technology manufacturer (including the manufacturer’s parent corporation, subsidiaries, affiliates, and associated corporations) or other interest groups? If yes, please provide the names of the companies and organizations, and outline the nature of these relationships, in the following box.

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| By checking this box, I hereby certify that the information that I have presented here is accurate and complete to the best of my knowledge | [ ]  |

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|  |  |  |  |
| Date |  | Name |  |