Cancer Care Ontario

Print Form

Case-by-Case Review Program
Appeals / Resubmission Form

Note: An appeal or resubmission to CBCRP will only be considered if this form is submitted to Cancer Care Ontario within 30 days of the initial funding decision.

Initial Request Tracking No. _____ OHIN _____

Treating Oncologist _____ (First) _____ (Last) Patient Name _____ (First) _____ (Last)

If you have additional information that was not submitted in your original request, file a RESUBMISSION.
If you have no new information but can describe how the policy was improperly applied or interpreted, file an APPEAL.

1. Select type of submission: ◯ **APPEAL** ◯ **RESUBMISSION**

Grounds for Appeal or Resubmission
For CBCRP to re-review a request, the applicant must provide a substantive response that addresses the issues raised in the rejection letter and/or clearly identifies a problem with how the policy was applied.

2. List and refute each reason for rejection stated in the rejection letter issued by CBCRP.

☐ Or check here, if you have attached a letter with this information

3. Provide any additional comments:

4. Required Documentation

☐ Attach the letter of rejection issued by CBCRP

☐ For resubmissions, attach any relevant supporting documentation (e.g., laboratory reports, imaging reports, etc.)

CCO may request additional information as necessary to adjudicate your case.

Consents and Approvals

☐ By checking this box, I confirm that the patient named above, or relevant substitute decision-maker where applicable, has been informed by the Applicant that the patient's Personal Health Information (PHI), as such term is defined in the *Personal Health Information Protection Act,* 2004, as amended, will be disclosed to and used by Cancer Care Ontario (CCO) in order to determine the patient's eligibility to receive funding for specific cancer drugs pursuant to the eligibility criteria as set out in the Case by Case Review Program. In order to determine eligibility for a specific drug, it may be necessary for CCO to disclose the patient's PHI to the Executive Officer (EO), Ontario Public Drug Program, as well as the patient's treating pharmacist.

☐ By checking this box, I confirm that the patient, or relevant substitute decision-maker where applicable, has provided his/her express consent for the disclosure and use of their PHI in accordance with the above stated purpose.

☐ By checking this box, I certify that the information set out in this Request Form is true and accurate, to the best of my knowledge.

Date Completed _____

Please submit this form and supporting documentation via CCO's secure upload tool at https://pdrp.cancercare.on.ca/.
Should you have any questions about this form or program, contact CBCRP at 416.971.9800 or cbcrp@cancercare.on.ca.

Ontario
Cancer Care Ontario