**ST-QBP Drug/Regimen/Universal Compassionate Access Request Form**

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| In addition to your regimen request, this form is also intended to support Ontario Health’s (OH) Disease Site Team (DST) to assess the request against the Systemic Treatment Quality-Based Program’s (ST-QBP) definition of an evidence-informed regimen.1. Upon receipt of your request, OH will perform an initial assessment. Follow-ups and amendments to the initial request may be required.
2. The finalized request will be reviewed by the DST, who will complete the check-list component below. The completed form with funding recommendation will serve as the decision note and response to your request.
3. Approved requests will be followed by updates to ST-QBP’s list of evidence-informed regimens, reflected on the website and an upcoming operational report (iPort).
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**Request*or Details***

**Name and Title:** Click here to enter text.

**Cancer Centre or Hospital Name:** Click here to enter text.

**E-mail:** Click here to enter text. **Date:** Click here to enter a date.

**Regimen Request**

**Disease Site**: Choose an item.

* **If other, please specify:** Click here to enter text.

**Sub-Disease Site**:

* **If not listed, please specify:** Click here to enter text.

**Request Drug or Regimen:** Click here to enter text. **Regimen Code** (if known)**:** Click here to enter text. **Treatment Intent:** [ ]  Adjuvant/Curative [ ]  Palliative [ ]  Adjuvant/Curative & Palliative  **Number of cycles** (For adjuvant/curative regimen requests only)**:
Regimen Details:**

**Reference(s):**Please list supporting reference(s) below and attach a full copy of the article/journal, outlining the evidence for clinical use. Note: if this information is not included, the regimen will not be reviewed.

**Universal Compassionate Access Program Criteria (if applicable):**

[ ]  The drug is part of a regimen that is considered evidence-informed by the disease site experts

[ ]  The drug is available to all patients in the province who meet the eligibility criteria

[ ]  The manufacturer is providing the drug free of charge to all patients (no screening for private insurance is conducted by the drug manufacturer)

[ ]  The drug has received Notice of Compliance approval from Health Canada

**All four criteria must be met to be considered as a universal compassionate access program.**

**Thank you for your request. Please send this form and a copy of the cited reference(s) to** **OH-CCO\_DrugFormulary@ontariohealth.ca** **If applicable, for universal compassionate access programs, please include a copy of the enrollment form and a letter from the manufacturer confirming the program will not screen for insurance in the province of Ontario**

 **For OH-CCO’s initial review: Amended regimen details, if required**

**For OH-CCO Disease Site Team Assessment**

[ ]  The results of a randomized Phase III trial are published, **OR**

[ ]  The results of the Phase II trial are published

* A randomized trial is not considered to be feasible, please specify rare cancer or other reason: Specify or enter reason here

 **Benefits of drug/regimen requested**:

* There is an unmet clinical need: [ ]  Yes [ ]  No [ ]  N/A Comments
* There is a clinically meaningful survival benefit (overall or progression free):

[ ]  Yes [ ]  No [ ]  N/A Comments

* This drug/regimen will improve a patient’s quality of life (less toxicity, reduced disease-related symptoms) or not cause a significant decrement in Quality of Life: [ ]  Yes [ ]  No [ ]  N/A Comments

**The drug/regimen will reduce health system pressures and is otherwise clinically equivalent (effectiveness, safety):**

* The drug/regimen will increase the efficiency or reduce workload of the cancer treatment facility:

[ ]  Yes [ ]  No [ ]  N/A Comments

* The drug/regimen is less costly than the comparator it could replace:

 [ ]  Yes [ ]  No [ ]  N/A Comments

* The drug/regimen provides patients with an option when the standard treatment cannot be used:

[ ]  Yes [ ]  No [ ]  N/A Comments

* If applicable, the compassionate access program meets the criteria for universal compassionate access:

[ ]  Yes [ ]  No [ ]  N/A Comments

**Recommendation:**

[ ]  Approve

[ ]  Do Not Approve

**Disease Site Team Member Name:** Comments

**Disease Site Team Lead Comments (optional):** Comments

**Date: Click here to enter a date.**