**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). |

**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**](mailto: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.**