Ontario Health
Cancer Care Ontario

Enrolment Form

CAR T-cell Therapy for Relapsed/Refractory Lymphoma (Third or Subsequent Line)

Note: This form should be completed and **funding approved** before apheresis is peformed.

Completed form and supporting documentation should be submitted through the online portal: https://mft.cancercare.on.ca.
Username: CARTSubmission
Password: Contact our program at **OH-CCO_CARTSubmissions@ontariohealth.ca**

Ontario Health collects and uses information on this form in order to determine if the patient meets the eligibility and funding criteria for the CAR T-cell Therapy Program, resulting in reimbursement to the treating facility. They also collect and use information on this form for purposes of analysis or compiling statistical information with respect to the management of, evaluation or monitoring of, the allocation of resources to or planning for all or part of the health system, including the delivery of services, pursuant to Section 45 of the Personal Health Information Protection Act, 2004.

As part of the evaluation of the request, it may be necessary for Ontario Health to disclose the patient's personal health information (PHI) to other administrative programs for health services and insured benefits at the Ministry of Health.

*Required Fields

1. Patient Profile

*Surname: _____

*Given Name: _____

*Date of Birth: DD-MMM-YYYY *(DD-MMM-YYYY or click arrow down button to use calendar to enter the date)*

*Gender: ◯ Male ◯ Female ◯ Other Height (cm): _____ Weight (kg): _____

*Province/Territory of Patient Residence: ◯ AB ◯ BC ◯ MB ◯ NB ◯ NL ◯ NT ◯ NS ◯ NU ◯ ON ◯ PE ◯ QC ◯ SK ◯ YT

*Postal Code of Patient Residence: A1A 1A1

*Provincial/Territorial Health Card Number: _____

Note: If your patient is not a resident of Ontario, a funding approval letter from the patient's provincial/territorial Ministry of Health is required.

2. Enroling Site

*Province/Territory of Referring Site: ◯ AB ◯ BC ◯ MB ◯ NB ◯ NL ◯ NT ◯ NS ◯ NU ◯ ON ◯ PE ◯ QC ◯ SK ◯ YT

*Enroling Site: _____

*Patient Chart Number (MRN) at Enroling Site: _____

*Enroling Physician: Given Name Surname

Enroling Physician CPSO Number (Ontario Only): _____

*Enroling Physician Specialty: _____

*Enroling Physician Email: _____

*Enroling Physician Cell Phone Number: XXX-XXX-XXXX

*Enroling Physician Fax Number: XXX-XXX-XXXX

Alternate Contact Email: _____

Note: If an alternate contact email is provided, the alternate contact will be copied on all email correspondence about this enrolment.

3. Treatment Centre and Product Information

Before submitting this form, confirm the CAR T-cell Therapy Centre has capacity and has agreed to treat your patient. Email or fax confirmation is required when submitting this enrolment package. CAR T-cell Therapy Centre contact details are available at https://www.cancercareontario.ca/en/find-cancer-services/car-t-cell-therapy-centres

*Will this patient receive CAR T-cell therapy in Ontario? ◯ Yes ◯ No

If patient will be treated **in Ontario**, select CAR T-cell therapy site:

◯ Juravinski Cancer Centre - Hamilton Health Sciences

◯ Princess Margaret Cancer Centre - University Health Network

◯ The Ottawa Hospital

If patient will be treated **in another province** in Canada, please provide CAR T-cell therapy site name and city/province: _____

If patient will be treated **out of country**, please indicate the treating facility:

◯ Roswell Park Comprehensive Cancer Center (Buffalo, New York)

◯ Cleveland Clinic (Cleveland, Ohio)

◯ Karmanos Cancer Institute (Detroit, Michigan)

If your patient will be treated out-of-country, please also complete section 8.

*Treating Physician at CAR T-cell therapy site: Given Name Surname

*Requested CAR T-cell therapy product:

◯ Kymriah (tisagenlecleucel)

◯ Yescarta (axicabtagene ciloleucel)

Note: Switching CAR T-cell products will require replacement of the original funding letter that was issued. Contact the program immediately in case there is a need to use another product.

Anticipated date of apheresis : DD-MMM-YYYY *(DD-MMM-YYYY or click arrow down button to use calendar to enter the date)*

4. Funding Criteria

***A. The patient must meet the following criteria:** ☐ I confirm that my patient meets the funding criteria outlined below:

- Patient has relapsed[1] or refractory[2] large B-cell lymphoma after two or more lines of systemic therapy for aggressive lymphoma including an anti-CD20 monoclonal antibody (unless the tumor is determined to be CD20 negative) and an anthracycline or etoposide containing chemotherapy regimen (e.g., R-CHOP)[3]
- Patient is sufficiently stable to facilitate planned CAR T-cell therapy (e.g., not rapidly progressing on temporizing therapy, no significant compromise of vital organ functions, no need for intubation or dialysis, does not require ICU/pressors and does not have active or uncontrolled infection) and has good performance status[4]
- Patient has not previously received a CAR T-cell therapy

***B. Patient has the following diagnosis[5,6]:**

Click arrow down to select a diagnosis (Do not write diagnosis on this field)

Notes: As evidence and clinical practice evolve, eligibility criteria is subject to change. Additional notes are provided on page 4.

1. Relapsed disease - indicates a complete remission/response to the last therapy prior to a biopsy-proven relapse or recurrence. Treatment responses are defined as per revised IWG Response Criteria for Malignant Lymphoma (Cheson et al., 2007).
2. Primary refractory disease - indicates progressive or stable disease as the best response to the first line standard therapy for aggressive lymphoma (e.g., R-CHOP). Refractory disease to second or greater line - indicates progressive disease or partial response as best response to the most recent therapy regimen.
3. Patients must have failed standard therapies (e.g., R-CHOP first line and platinum-containing salvage chemotherapy) to be considered for CAR T-cell therapy.
4. Patients with active primary CNS lymphoma are currently not eligible for funding. For patients who experienced early or isolated CNS relapse or asynchronous systemic and CNS disease and have received or completed systemic and CNS disease treatments separately, standard therapy, or regimen for the treatment of active secondary CNS lymphoma (e.g., HD-methotrexate and cytarabine or MATRIX regimen) may be considered as a separate line of treatment.
5. Diagnoses not specifically included in the Health Canada approved product monographs or have not been approved for public funding may not be eligible for consideration. Transformations of indolent lymphomas and rare subtypes of large B-cell lymphomas (LBCL) recognized by the most current World Health Organization (WHO) classification may be considered as long as the patient has received two or more lines of systemic therapy for aggressive lymphoma (i.e.,DLBCL) as indicated above.
6. Patients with Richter's transformation from chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) are curently not eligible for funding.

5. Treatment History

*A. How many lines of systemic therapy against aggressive lymphoma (e.g., DLBCL) has the patient previously received? ◯2 ◯3 or More

*B. Did the patient have a previous autologous stem cell transplant (ASCT)? ◯Yes ◯No

i. If yes, provide further details on the table below.

ii.If no, please indicate the reason for ineligibility or for not undergoing ASCT: Click arrow down to select reason

If other, explain:

Date Initiated	Date Completed	Name of Therapy/Regimen	No. of Cycles (if applicable)	Best Response to Therapy
MMMM, YYYY	MMMM, YYYY			Click arrow down to select
MMMM, YYYY	MMMM, YYYY			Click arrow down to select
MMMM, YYYY	MMMM, YYYY			Click arrow down to select
MMMM, YYYY	MMMM, YYYY			Click arrow down to select
MMMM, YYYY	MMMM, YYYY			Click arrow down to select
MMMM, YYYY	MMMM , YYYY			Click arrow down to select

*C. Did the patient have a previous allogeneic stem cell transplant? ◯Yes ◯No

i. If yes, provide the date of the patient's allogeneic stem cell transplant? MMMM, YYYY *(Click arrow down button to use calendar to enter the date)*

ii. Did the patient experience graft versus host disease (GvHD)? ◯Yes ◯No

If yes, a. Does the patient have active GvHD? ◯Yes ◯No

b. Is the patient still undergoing treatment for GvHD? ◯Yes ◯No

*D. Did the patient receive any prior non-cellular anti-CD19 therapy? ◯Yes ◯No

If yes, i. Provide the date when the patient received the therapy: MMMM, YYYY *(Click arrow down button to use calendar to enter the date)*

ii. Specify the non-cellular anti-CD19 therapy: ◯Blinatumomab ◯Tafasitamab ◯Other :

6. Confirmation of Patient Suitability for Therapy

*A. CNS disease status:

◯No active CNS lymphoma
◯Active primary CNS lymphoma (not eligible for CAR T-cell therapy)
◯Active secondary CNS lymphoma
◯Treated/inactive primary CNS lymphoma
◯Treated/inactive secondary CNS lymphoma

*B. Patient has acute life threatening bacterial, viral (HIV, active hepatitis B or C) or fungal infection or an inflammatory disorder:

◯No Infection
◯Controlled Infection
◯Uncontrolled Infection

*C. Karnofsky Performance Status (KPS) ≤70%: ◯Yes ◯No

Date of KPS assessment: DD-MMM-YYYY *(DD-MMM-YYYY or click arrow down button to use calendar to enter the date)*

Renal Function:

*D. Creatinine ≥141.44 µmol/L (1.6 mg/dL): ◯Yes ◯No

*E. Estimated glomerular filtration rate (eGFR) ≤45 ml/min/1.73m^2: ◯Yes ◯No

Liver Function:

*F. ALT or AST ≥3x upper limit of normal value: ◯ Yes ◯ No

*G. Bilirubin ≥2x upper limit of normal value: ◯ Yes ◯ No

Pulmonary Function:

*H. Pulse oxygenation ≤91% on room air: ◯ Yes ◯ No

Cardiac Function:

*I. Left ventriclular ejection fraction (LVEF) ≤40% confirmed by echocardiogram or multiple-gated acquisition (MUGA) scan or radionuclide angiography: ◯ Yes ◯ No

Bone Marrow Function:

*J. Absolute neutrophil count (ANC) ≤1.0x10^9/L: ◯ Yes ◯ No

*K. Absolute lymphocyte count (ALC) <0.1x10^9/L: ◯ Yes ◯ No

Note: If ALC is below 0.1x10^9/L, application can be considered; but for apheresis to proceed, ALC must be at least 0.1x10^9/L.

*L. Hemoglobin ≤80 g/L (8.0 g/dL) and/or transfusion dependent: ◯ Yes ◯ No

*M. Platelets ≤50x10^9/L: ◯ Yes ◯ No

7. Additional Notes

a. Treatment with either tisagenlecleucel or axicabtagene ciloleucel is a one-time therapy.
b. Tisagenlecleucel or axicabtagene ciloleucel should not be used in combination with other treatments for relapsed/refractory lymphoma.
c. At least six weeks must have elapsed from any prior systemic inhibitory/stimulatory immune checkpoint molecule therapy (e.g., nivolumab, pembrolizumab, etc.) to the time of CAR T-cell product infusion.
d. A patient with another malignancy must be in complete remission with said malignancy prior to receiving CAR T-cell therapy.
e. Patients who have had an autologous stem cell transplant in the last 100 days must meet funding criteria at the time of enrolment.
f. Patients who have had an allogeneic stem cell transplant and have no active graft versus host disease (GvHD) and are not on immunosuppressive therapy may be eligible for CAR T-cell therapy.
g. For CNS lymphomas, active CNS disease is defined as recent neurologic sign/symptoms, and/or positive imaging studies (MRI, PET scan) and/or positive cerebrospinal fluid (CSF) study.
h. Patients with an active, uncontrolled infection should not start treatment with CAR T-cell therapy until the infection has resolved or has been appropriately treated. This includes both the lymphodepleting chemotherapy and the CAR T-cell infusion.
i. Patients must meet the funding criteria at the time of enrolment and must continue to be eligible and suitable for therapy at the time of product infusion.

8. Out-of-Country Applications - Additional Requirements

Only complete this section if you are an Ontario physician applying for an Ontario patient to be treated out-of-country:

1. Submit all the documents listed under "Supporting Documents" in section 10.
2. Download, complete and submit the Ministry form “Request for Prior Approval for Full Payment of Insured Out-of-Country (OOC) Health Services."

- The form can be found in the Central Forms Repository at: http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?OpenForm&ACT=RDR&TAB=PROFILE&SRCH=&ENV=WWE&TIT=4520&NO=014-4520-84
- Complete as indicated below:
  - Part 1: Patient name, mailing address and phone number only
  - Part 2: Physician name and office address only
  - Part 3: All fields
  - Part 5: All fields up to but not including anything after “If treatment is not available in Ontario”
  - Parts not required: Part 4, 6, and patient/physician signatures

9. Acknowledgement

☐ *Yes, I confirm that the patient named above, or relevant substitute decision-maker where applicable, consents that

Ontario Health collects and uses information on this form to make funding decisions pursuant to section 38(1)(b) of the Personal Health Information Protection Act, 2004; and for the purpose of analysis or compiling statistical information with respect to the management of, evaluation or monitoring of, the allocation of resources to or planning for all or part of the health system, including the delivery of services, pursuant to section 45 of the Personal Health Information Protection Act, 2004. As part of the evaluation and reimbursement process for CAR T-cell Therapy Program, it may be necessary for Ontario Health to disclose or share the patient's personal health information to other administrative programs for health services and insured benefits at the Ministry of Health or at Ontario Health.

10. Supporting Documents

If the enrolment is for an Out-of-Country treatment for an Ontario patient, the following documentation (from **Lists A and B**) **must be** submitted with the enrolment form. The Ministry form "Request for Prior Approval for Full Payment of Insured Out-of-Country (OOC) Health Services" must also be included in the enrolment package.

If the enrolment is for in-Ontario treatment, the documents under **List A must be** submitted and documents under **List B** should be available upon request (including for the purpose of audit) to confirm eligibility.

***List A: Required upon enrolment**

- ☐ If any of the answers to section 6 are "Yes", submit relevant and recent laboratory results showing adequate organ function (e.g., kidney and liver function tests, viral serology, cardiac ECHO/MUGA)
- ☐ Pathology report
- ☐ Recent clinic notes that describe the patient's current clinical status and rationale for CAR T-cell therapy over other treatment options. Include any specialist notes (e.g., BMT, neurology, nephrology, cardiology) that informed the treatment plan
- ☐ If the request is from a treating physician outside an Ontario CAR T-cell treating facility, email or fax from the treating facility/physician confirming that they have capacity and willing to accept this patient
- ☐ If the request is for treatment out-of-country, email or fax from the Ontario T-cell treating facilities confirming no capacity and email or fax from the out of country treating facility confirming their capacity and willing to accept this patient
- ☐ If the request is for a non-Ontario resident, a funding approval letter from the patient's provincial/territorial Ministry of Health is required, specifying CAR T-cell product(s) that is/are funded by the patient's provincial/territorial Ministry of Health

List B: Available upon request

- ☐ Bone Marrow (BM) studies including most recent studies
- ☐ Cerebrospinal Fluid (CSF) studies documenting CNS disease status (within the last 30 days)
- ☐ Documentation of CD19 tumour expression in BM or peripheral blood by flow cytometry (if done)
- ☐ Pre and post-treatment imaging reports e.g., CT scan (post-treatment imaging reports must be within the last 30 days)
- ☐ Multidisciplinary cancer conference (MCC)/tumour board notes (if available)

*By checking this box, I certify that the information set out in this questionnaire is true and accurate, to the best of my knowledge: ☐ Yes

*Enroling Physician: Given Name Surname *Date: DD-MMM-YYYY *(DD-MMM-YYYY or click arrow down button to use calendar to enter the date)*

Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, info@ontariohealth.ca