

## CADTH Feedback on Draft Recommendation

### Instructions for Stakeholders

This template is for eligible stakeholders to provide feedback and comments on draft recommendations. Draft recommendations are available for feedback for 10 business days.

CADTH will consider feedback received from eligible stakeholders, including the sponsor, the payers, patient groups, and clinician groups. Individuals interested in providing feedback should contact the relevant patient and clinician organizations. This template may also be used by eligible industry stakeholders to provide feedback on draft recommendations.

The sponsor may use this form to provide general feedback on the draft recommendation if they are not filing a request for reconsideration. If the sponsor is filing a request for reconsideration, they must complete the [reconsideration template](#) and should not complete this template.

All submitted feedback must be disclosable and will be posted on the CADTH website.

If you have questions, please email [requests@cadth.ca](mailto:requests@cadth.ca) with the complete details of your question(s).

### Completing the Template:

Feedback should be presented clearly and succinctly in point form, whenever possible. The issue(s) should be clearly stated and specific reference must be made to the section of the recommendation document under discussion (i.e., page number, section title, and paragraph).

Comments should be restricted to the content of the draft recommendation and should not contain any language that could be considered disrespectful, inflammatory or could be found to violate applicable defamation law.

Feedback must be based on the information that was considered by the expert committee in making the draft recommendation. No new evidence will be considered at this part of the review process.

Feedback must not exceed 3 pages in length, using a minimum 11-point font on 8.5" by 11" paper. If comments exceed 3 pages, the feedback will not be accepted by CADTH. References may be provided separately; however, these cannot be related to new evidence.

**Patient groups must complete Appendix 1.**

**Clinician groups must complete Appendix 2.**

### Filing the Completed Template:

The feedback must be provided in Microsoft Word format. In order to ensure fairness in CADTH's procedures, all stakeholder feedback must be received by the deadline posted on the CADTH website.

# CADTH Feedback on Draft Recommendation

Stakeholder information		
CADTH project number		
Brand name (generic)		
Indication(s)		
Organization		
Contact information <sup>a</sup>	Name:	
Stakeholder agreement with the draft recommendation		
<b>1. Does the stakeholder agree with the committee's recommendation.</b>	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
Please explain why the stakeholder agrees or disagrees with the draft recommendation. Whenever possible, please identify the specific text from the recommendation and rationale.		
Expert committee consideration of the stakeholder input		
<b>2. Does the recommendation demonstrate that the committee has considered the stakeholder input that your organization provided to CADTH?</b>	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
If not, what aspects are missing from the draft recommendation?		
Clarity of the draft recommendation		
<b>3. Are the reasons for the recommendation clearly stated?</b>	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
If not, please provide details regarding the information that requires clarification.		
<b>4. Have the implementation issues been clearly articulated and adequately addressed in the recommendation?</b>	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
If not, please provide details regarding the information that requires clarification.		
<b>5. If applicable, are the reimbursement conditions clearly stated and the rationale for the conditions provided in the recommendation?</b>	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
If not, please provide details regarding the information that requires clarification.		

<sup>a</sup> CADTH may contact this person if comments require clarification.

## Appendix 1. Conflict of Interest Declarations for Patient Groups

- To maintain the objectivity and credibility, all participants in the review processes must disclose any real, potential, or perceived conflicts of interest.
- This conflict of interest declaration is required for participation. Declarations made do not negate or preclude the use of the feedback from patient groups and clinician groups.
- CADTH may contact your group with further questions, as needed.

A. Patient Group Information				
<b>Name</b>	<i>Please state full name</i>			
<b>Position</b>	<i>Please state currently held position</i>			
<b>Date</b>	<i>Please add the date form was completed (DD-MM-YYYY)</i>			
<input type="checkbox"/>	I hereby certify that I have the authority to disclose all relevant information with respect to any matter involving this patient group with a company, organization, or entity that may place this patient group in a real, potential, or perceived conflict of interest situation.			
B. Assistance with Providing Feedback				
<b>1. Did you receive help from outside your patient group to complete your feedback?</b>	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>		
If yes, please detail the help and who provided it.				
<b>2. Did you receive help from outside your patient group to collect or analyze any information used in your feedback?</b>	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>		
If yes, please detail the help and who provided it.				
C. Previously Disclosed Conflict of Interest				
<b>1. Were conflict of interest declarations provided in patient group input that was submitted at the outset of the CADTH review and have those declarations remained unchanged? If no, please complete section D below.</b>	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>		
D. New or Updated Conflict of Interest Declaration				
<b>3. List any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the device under review.</b>				
Company	Check Appropriate Dollar Range			
	\$0 to 5,000	\$5,001 to 10,000	\$10,001 to 50,000	In Excess of \$50,000
<i>Add company name</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Add company name</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Add or remove rows as required</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Appendix 2. Conflict of Interest Declarations for Clinician Groups

- To maintain the objectivity and credibility, all participants in the review processes must disclose any real, potential, or perceived conflicts of interest.
- This conflict of interest declaration is required for participation. Declarations made do not negate or preclude the use of the feedback from patient groups and clinician groups.
- CADTH may contact your group with further questions, as needed.
- For conflict of interest declarations:
  - Please list any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the device under review.
  - Please note that declarations are required for each clinician that contributed to the input.
  - If your clinician group provided input at the outset of the review, only conflict of interest declarations that are new or require updating need to be reported in this form. For all others, please list the clinicians who provided input are unchanged
  - Please add more tables as needed (copy and paste).
  - All new and updated declarations must be included in a single document.

A. Assistance with Providing the Feedback		
2. Did you receive help from outside your clinician group to complete this submission?	No	<input type="checkbox"/>
	Yes	<input type="checkbox"/>
If yes, please detail the help and who provided it.		
3. Did you receive help from outside your clinician group to collect or analyze any information used in this submission?	No	<input type="checkbox"/>
	Yes	<input type="checkbox"/>
If yes, please detail the help and who provided it.		
B. Previously Disclosed Conflict of Interest		
4. Were conflict of interest declarations provided in clinician group input that was submitted at the outset of the CADTH review and have those declarations remained unchanged? If no, please complete section C below.	No	<input type="checkbox"/>
	Yes	<input type="checkbox"/>
If yes, please list the clinicians who contributed input and whose declarations have not changed: <ul style="list-style-type: none"> <li>• Clinician 1</li> <li>• Clinician 2</li> <li>• Add additional (as required)</li> </ul>		

### C. New or Updated Conflict of Interest Declarations

New or Updated Declaration for Clinician 1	
<b>Name</b>	<i>Please state full name</i>
<b>Position</b>	<i>Please state currently held position</i>
<b>Date</b>	<i>Please add the date form was completed (DD-MM-YYYY)</i>
<input type="checkbox"/>	<b>I hereby certify</b> that I have the authority to disclose all relevant information with respect to any matter involving this clinician or clinician group with a company, organization, or entity that may place this clinician or clinician group in a real, potential, or perceived conflict of interest situation.
Conflict of Interest Declaration	

List any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the device under review.

Company	Check Appropriate Dollar Range			
	\$0 to 5,000	\$5,001 to 10,000	\$10,001 to 50,000	In Excess of \$50,000
Add company name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Add company name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Add or remove rows as required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### New or Updated Declaration for Clinician 2

<b>Name</b>	Please state full name
<b>Position</b>	Please state currently held position
<b>Date</b>	Please add the date form was completed (DD-MM-YYYY)

- I hereby certify** that I have the authority to disclose all relevant information with respect to any matter involving this clinician or clinician group with a company, organization, or entity that may place this clinician or clinician group in a real, potential, or perceived conflict of interest situation.

### Conflict of Interest Declaration

List any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the device under review.

Company	Check Appropriate Dollar Range			
	\$0 to 5,000	\$5,001 to 10,000	\$10,001 to 50,000	In Excess of \$50,000
Add company name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Add company name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Add or remove rows as required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### New or Updated Declaration for Clinician 3

<b>Name</b>	Please state full name
<b>Position</b>	Please state currently held position
<b>Date</b>	Please add the date form was completed (DD-MM-YYYY)

- I hereby certify** that I have the authority to disclose all relevant information with respect to any matter involving this clinician or clinician group with a company, organization, or entity that may place this clinician or clinician group in a real, potential, or perceived conflict of interest situation.

### Conflict of Interest Declaration

List any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the device under review.

Company	Check Appropriate Dollar Range			
	\$0 to 5,000	\$5,001 to 10,000	\$10,001 to 50,000	In Excess of \$50,000
Add company name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Add company name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Add or remove rows as required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

New or Updated Declaration for Clinician 4				
<b>Name</b>	<i>Please state full name</i>			
<b>Position</b>	<i>Please state currently held position</i>			
<b>Date</b>	<i>Please add the date form was completed (DD-MM-YYYY)</i>			
<input type="checkbox"/>	<b>I hereby certify</b> that I have the authority to disclose all relevant information with respect to any matter involving this clinician or clinician group with a company, organization, or entity that may place this clinician or clinician group in a real, potential, or perceived conflict of interest situation.			
Conflict of Interest Declaration				
List any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the device under review.				
Company	Check Appropriate Dollar Range			
	\$0 to 5,000	\$5,001 to 10,000	\$10,001 to 50,000	In Excess of \$50,000
<i>Add company name</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Add company name</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Add or remove rows as required</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

New or Updated Declaration for Clinician 5				
<b>Name</b>	<i>Please state full name</i>			
<b>Position</b>	<i>Please state currently held position</i>			
<b>Date</b>	<i>Please add the date form was completed (DD-MM-YYYY)</i>			
<input type="checkbox"/>	<b>I hereby certify</b> that I have the authority to disclose all relevant information with respect to any matter involving this clinician or clinician group with a company, organization, or entity that may place this clinician or clinician group in a real, potential, or perceived conflict of interest situation.			
Conflict of Interest Declaration				
List any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the device under review.				
Company	Check Appropriate Dollar Range			
	\$0 to 5,000	\$5,001 to 10,000	\$10,001 to 50,000	In Excess of \$50,000
<i>Add company name</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Add company name</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Add or remove rows as required</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>