

## Welcome to BC PharmaCare's Public Input Questionnaire for drugs being reviewed under the B.C. Drug Review Process.

This questionnaire is for **[drug generic and brand name appears here]**.

**Patient Groups have to register before completing the questionnaire.** Not sure your group is registered? Check our list of [registered groups](#).

Your group can complete this patient group questionnaire only once. If you submit multiple questionnaires, only your last submission will be sent to the Drug Benefit Council for consideration.

**To protect the privacy of members in your group, please do not include in your response names of individuals or companies, locations, or any other information that might identify them or anyone else.**

### Completing the questionnaire

**Mandatory questions are flagged with a red asterisk (\*).**

*If you decide not to provide the required information, click the CANCEL button at the bottom of this page to exit the questionnaire. To protect your privacy, your browser window will close.*

You do not need to answer all the optional questions. You need only answer those that you think apply to patients in your group.

To protect your privacy, please close this browser window after you complete this questionnaire.

### Respondent information

**To have your input accepted, you must complete the Confirmation of Eligibility, Contact Information and Conflict of Interest Declaration sections of this questionnaire.**

### Confirmation of eligibility

1. I am a resident of British Columbia, **AND**

I am an authorized member of a Patient Group that represents B.C. patients who have the condition or disease for which this drug is used.\*

Yes

No

## Contact Information

**Your organization's contact information will only be used to retrieve your submission if you submit a request under the Freedom of Information and Protection of Privacy Act (FOIPPA). It will not be used for any other purpose.**

Your organization's name, however, will be included as part of your submission to the Drug Benefit Council.

2. **Patient Group Name and name of representative completing this questionnaire\***

3. **Organization's Address \***

4. **Postal Code \***

## Conflict of Interest Declaration

To make sure the Drug Review process is objective and credible, everyone who provides input has to tell us about any possible conflict of interest.

A conflict of interest exists if you, an immediate family member or your organization might benefit from the outcome of the review. For example, if you or your family own stock in the company that makes the drug, there could be a financial benefit IF PharmaCare decides to cover the drug. If your organization receives funding from the drug company, there could be a financial benefit (such as ongoing or increased funding) IF PharmaCare decides to cover the drug.

Examples of conflicts of interest include, but are not limited to, financial support from the pharmaceutical industry (e.g., educational or research grants, honoraria, gifts and salary) as well as affiliations or commercial relationships with drug manufacturers or other interest groups.

Even if you or an immediate family member, or your organization, has a conflict of

interest, your input will still be considered as long as you declare the conflict of interest in your answers to the questions. All information you provide is protected under the Freedom of Information and Protection of Privacy Act.

5. Do you have any Conflict(s) of Interest to declare?  
(If you answer "yes," please complete Question 6 below.)\*

- Yes  
 No

6. Describe any Conflict(s) of Interest below.  
(Complete this question only if you answered "yes" to the previous question)

## Questions on drug under review

Question 7 is mandatory; all other questions in this section are optional.

7. Have you read the PharmaCare information sheet for this drug?\*

If you would like to read this information now, click on the "this drug's information sheet" link in the *What this drug is for* column of the [List of Drugs Under Review](#). The information sheet will open in a new window.

\*

- Yes, I have read the information sheet  
 No, I have not read the information sheet

8. Describe how the condition or disease for which this drug is used affects the day-to-day life of patients in your group.

9. If the patients in your group have tried the drug under review, please tell us about the effects they experienced.

10. What drugs or other treatments have the patients in your group used, or are currently using, for

the condition or disease for which this drug is used?

*Please list all of the drugs and tell us about the experience of the patients in your group with each treatment.*

11. Please tell us why your organization believes this drug should be included in the BC PharmaCare program.

## Conclusion

Thank you for your organization's input to B.C. PharmaCare's review of this drug.

Once the survey period for this drug ends, we will send everyone's responses to the Drug Benefit Council for consideration when they make their drug coverage recommendations.

Before your input is forwarded to the Drug Benefit Council, we will remove all personal information, including the name(s) of patients and any other identifying details. The name of your organization, however, will be included as part of your submission.

Would you like to learn more about the drug review process? Visit the [drug review process overview](#) on the PharmaCare website.

Would you like to learn about the drug review decisions? Visit the [PharmaCare drug coverage decision summaries](#) on the PharmaCare website.

*Click the DONE button to submit your input and close this questionnaire.*

**After you have clicked "DONE," your browser may ask you whether you want to close the questionnaire window. To protect your privacy, please answer "yes" at the "close this window?" prompt.**