Patient and Health Care Provider Input: Non-Medical Biosimilar Switch Policy for Patients with Inflammatory Bowel Disease

August 2019
Crohn’s and Colitis Canada

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INTRODUCTION

Crohn's and Colitis Canada undertook a study into the perspectives of key stakeholders including patients, gastroenterologists and inflammatory bowel disease (IBD) nurses on biosimilars and related policy, including non-medical switch policy. The study findings are based on the results of qualitative research in the form of surveys of the identified key stakeholders.

ISSUE

In 2016, there was general consensus amongst the IBD scientific and medical community that patients in remission being treated with an innovator biologic should not be forced to switch to a biosimilar. At that time, it was considered that there was insufficient scientific evidence to show that patients responded as well to a biosimilar when switched from the innovator biologic. Since then, new international evidence that may or may not be applicable to the Canadian environment has accumulated and provincial jurisdictions (and private payers) are considering policy changes that will affect patients with IBD.

OBJECTIVE

The objective of this study is to contribute key stakeholder input toward Crohn's and Colitis Canada's updated position on biosimilars.

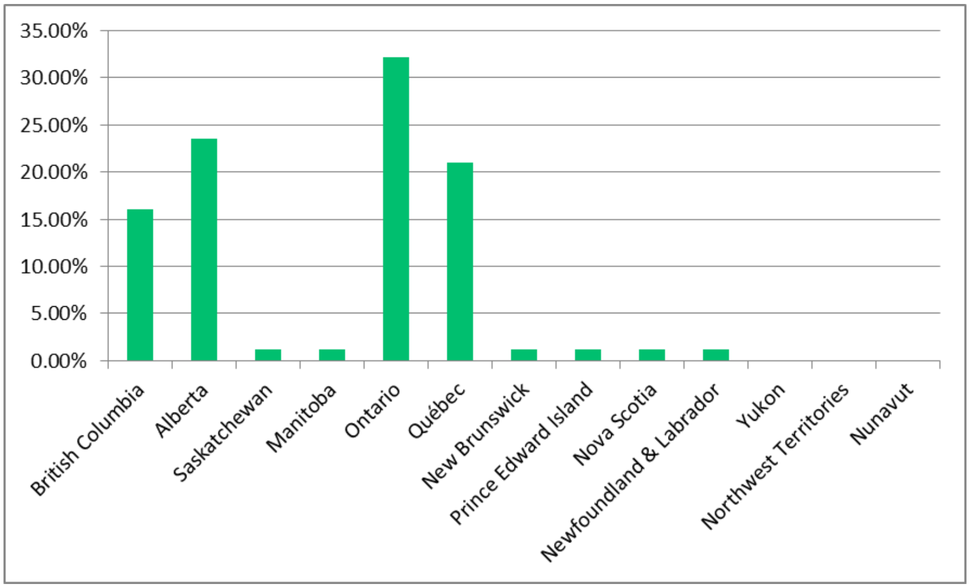
METHODS

Crohn's and Colitis Canada conducted a series of online surveys of patients, gastroenterologists and IBD nurses from across Canada. In total 82 gastroenterologists (Figure 1), 45 IBD nurses (Figure 2) and 796 patients (85%) and caregivers (15%) (Figure 3-5) participated across Canadian provinces and territories and across urban and rural settings. KTE Bridge Consulting contributed to the content of the three surveys and provided analysis and reporting support.

Respondents:

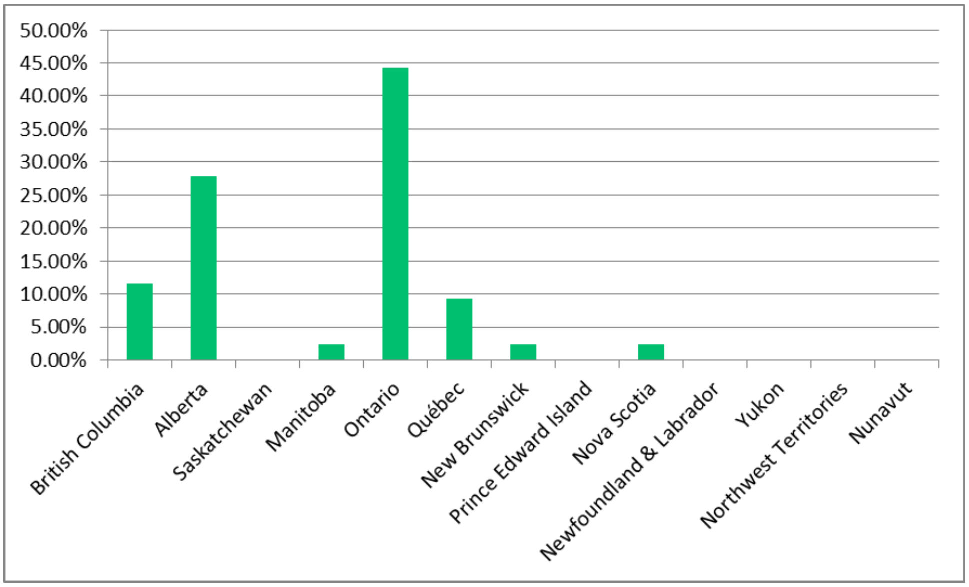
Gastroenterologists

Figure 1 – Gastroenterologist Respondents



IBD Nurses

Figure 2 – IBD Nurse Respondents



Patients and Caregivers

Figure 3 – Patient and Caregiver Respondents

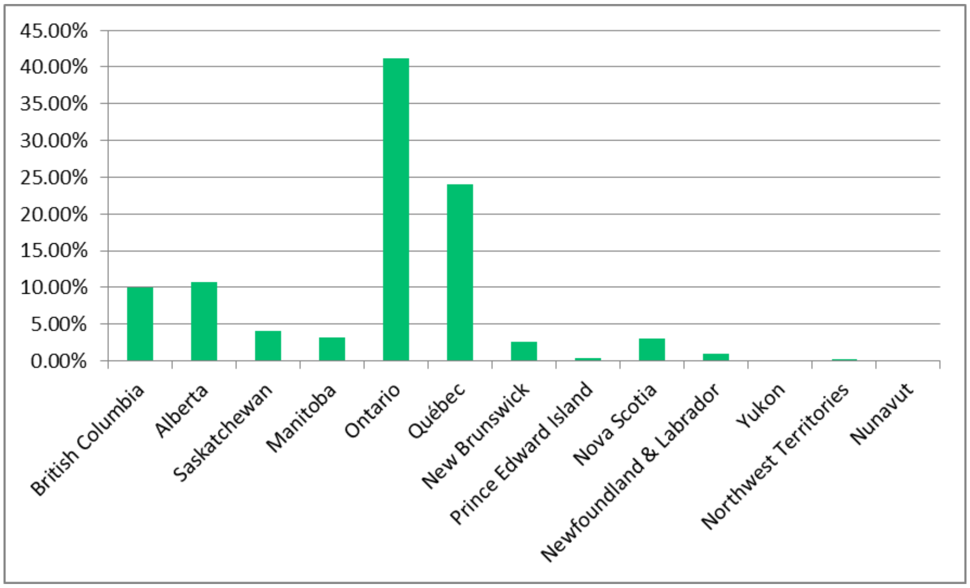


Figure 4 – Patient and Caregiver Respondents

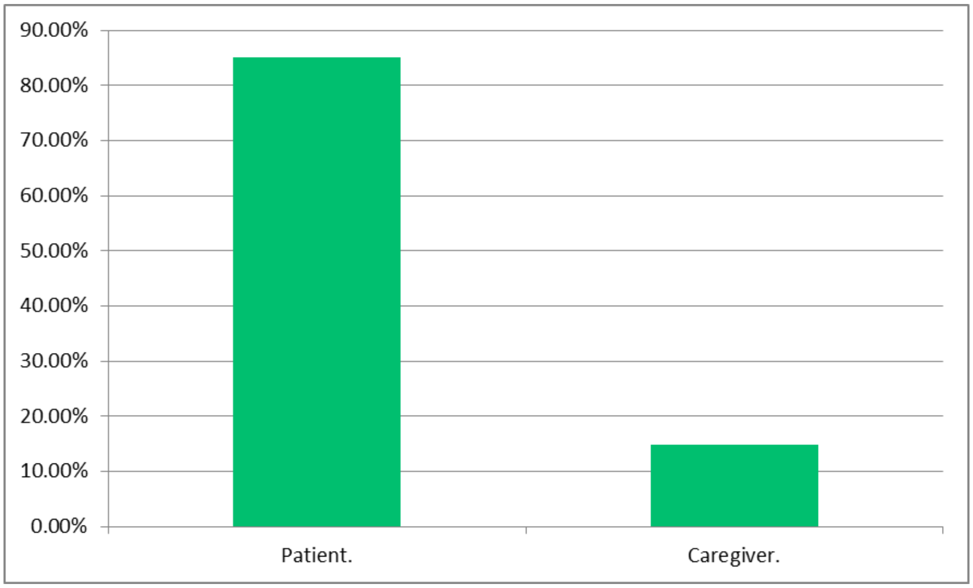
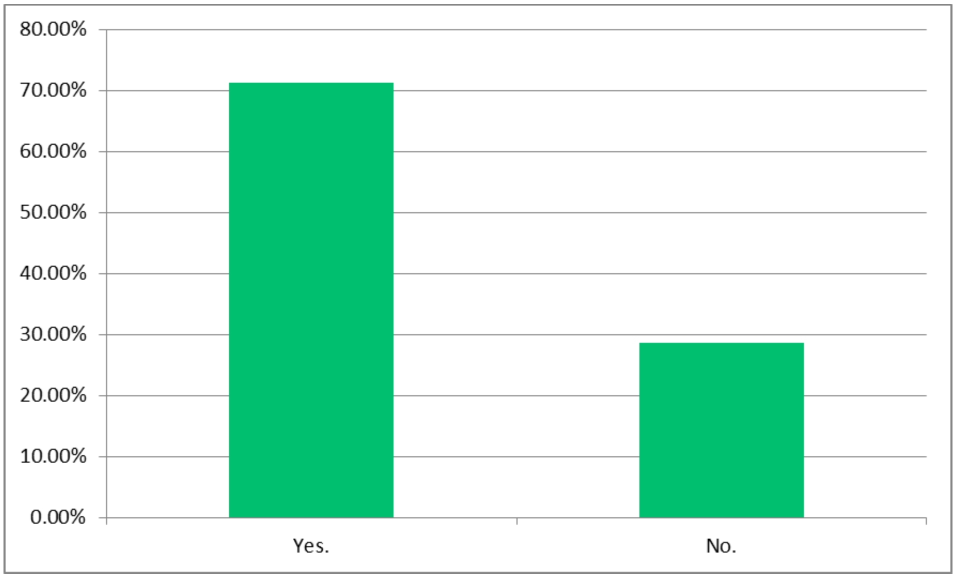


Figure 5 – Patient Caregiver Location – Number in Urban Area



Patients were contacted via Crohn's and Colitis social media channels over two separate days including Facebook, Instagram and Twitter. Gastroenterologists and IBD nurses were contacted via email utilizing internal Crohn's and Colitis Canada database contacts. Additional promotion of the survey to gastroenterologists and IBD nurses was realized through provincial gastroenterology associations and individual key opinion leaders. Targeted emails to specialist gastroenterologists treating pregnant patients and pediatric patients were also sent. The surveys and emails were shared in English and French.

STRENGTHS AND LIMITATIONS

The strength of this study lies in the quality and detail of the responses and comments offered by survey participants. Survey participants offered personal reflections and experiences as well as detailed explanations for their position.

The limitations of this study include the relatively small number of gastroenterologist and gastroenterology nurse specialist responses as well as the study's inherent self-selection bias. Not all provinces and territories were represented for each of the key stakeholder groups surveyed. Additionally, responses from Ontario were most numerous across all stakeholder groups.

RESULTS

Gastroenterologists

Participants

Of the gastroenterologists surveyed, 32% were from Ontario, 23% were from Alberta, 16% were from British Columbia and 21% were from Québec. A small number of surveys were received from gastroenterologists in Saskatchewan, Manitoba, New Brunswick, Nova Scotia, Newfoundland and Labrador and Prince Edward Island. Nunavut, Northwest Territories and Yukon did not have any gastroenterologist respondents. The majority of participants (58%) reported more than 100 patients with Crohn's and ulcerative colitis in their practice, with patients predominantly over 18 years of age (75%). Most gastroenterologist participants reported that their practice was in a major academic centre (67%).

Safety and Effectiveness

Overwhelmingly, these participants agreed (84%) that biosimilars offer safe and effective treatments for people with IBD (Figure 6), though 20% of responding gastroenterologists treating paediatric patients disagreed. Participants were less certain when asked if there is sufficient evidence to show that patients respond as well to the biosimilar when switched from an innovator biologic, 52% agreed, 24% disagreed and 24% felt they did not have enough information on biosimilars to answer (Figure 7). For gastroenterologists treating paediatric patients, 47% agreed, 33% disagreed and 20% felt they did not have enough information. When asked if a one-time switch from the infliximab biologic Remicade® to the biosimilar Inflectra® or Renflexis® was safe and effective 53% agreed, 30% disagreed and 17% required more information on biosimilars to answer (Figure 8). Responses from gastroenterologists treating paediatric patients were similar; 53% agreed, 27% disagreed and 20% required more information.

Figure 6 – Biosimilars Offer Safe and Effective Treatment

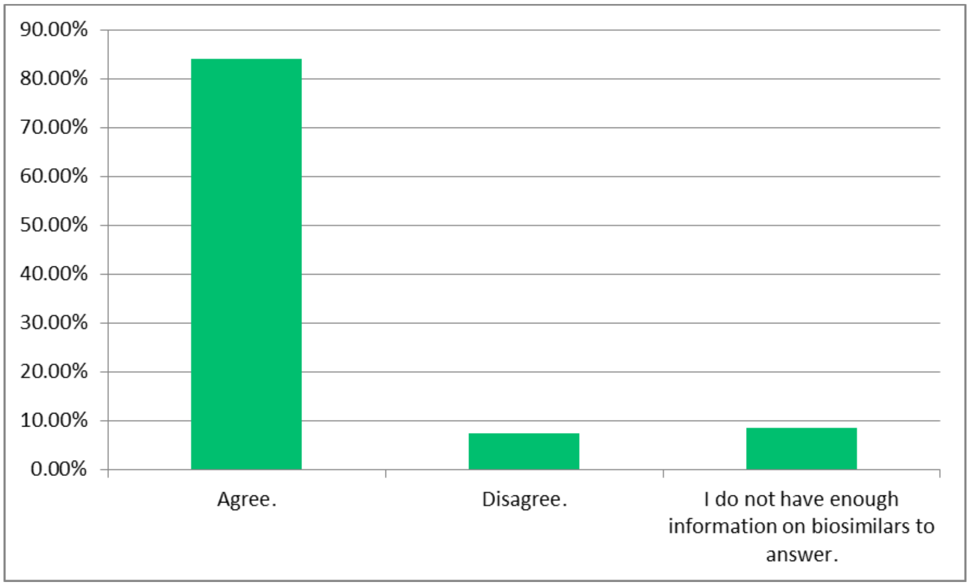


Figure 7 – Sufficient Evidence Indicating Comparable Patient Response

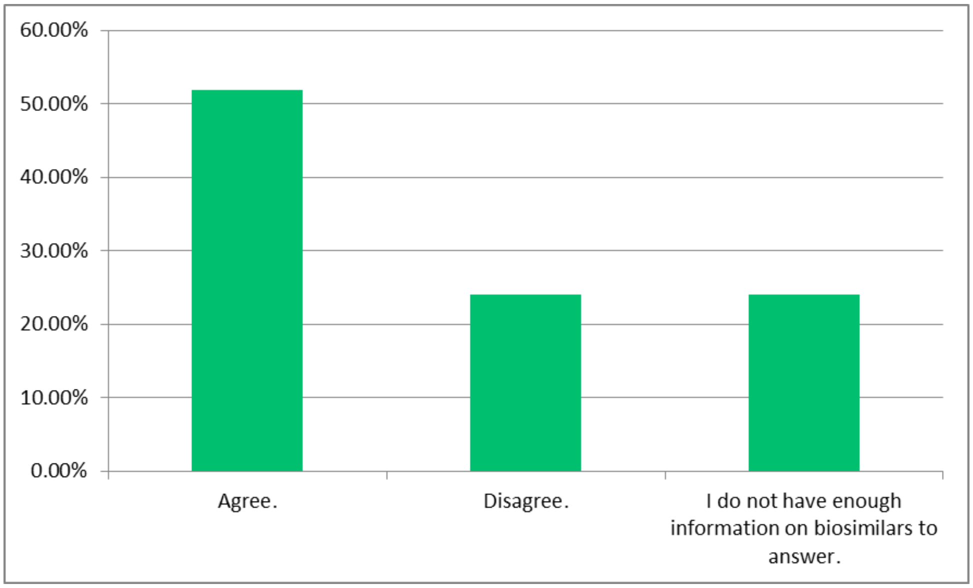
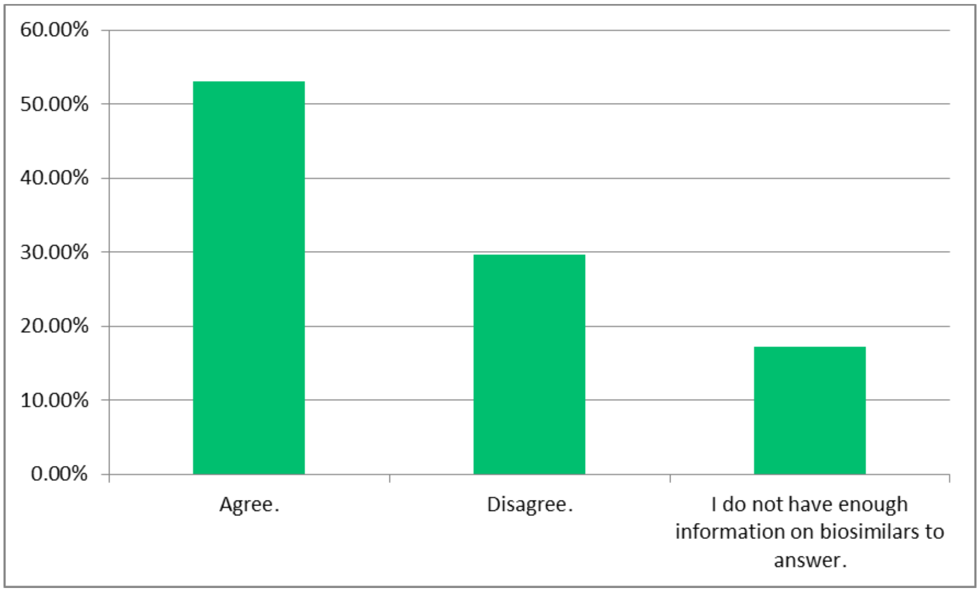


Figure 8 – One-Time Switch From Innovator Biologic to Biosimilar Is Safe and Effective



Required Patient Support

Gastroenterologists who responded to the survey agreed that should a one-time switch policy from the infliximab biologic Remicade® to the biosimilar Inflectra® or Renflexis® be enforced, they would require a number of supports for their patients including information pamphlets, an infoline to which they may refer patients, and a dedicated telephone number for patients to receive information.

Of the additional support suggested by participants through offered comments, 52% included dedicated staff including psychological support, 11% discussed financial information and support, and 18% took the opportunity to comment on the importance of doctor/patient decision-making. Complete comments are included in Appendix 2.

- "I need to directly contacted and have a dedicated coordinator to facilitate re-reimbursement issues and care implications"
- "Dedicated biologic coordinator with nursing background"
- "Financial support to patients that do not do well"
- "There is a potential for significant psychological impact on the patient regardless of what the evidence states. This necessitates an honest and informed discussion between the care provider and the patient. Logistically, if this was enforced it would take a significant amount of resources to do this right especially if you are a large prescriber of biologic therapy"
- "No, this should be a decision made between the patient and physician"

Medical Exceptions

Gastroenterologist participants were asked to consider the circumstances that would cause them to consider that a patient is medically unable to transition to a biosimilar from the innovator biologic. Of the responses received a small number (9%) indicated that there were no circumstances to consider a patient medically unable to switch and a much larger number (70%) of gastroenterologist suggested that patients with difficult to control disease may be an exemption.

Interestingly, of those gastroenterologists who considered that a one-time switch may be acceptable, 66% indicated that they considered medical exceptions to this intervention. The majority of these exceptions (55%) were patients with difficult to control disease.

Gastroenterologists who identified that they treated paediatric patients were almost unanimous in suggesting medical exceptions for their patients (97%). The majority of these respondents indicated that they would consider exceptions for patients difficult to treat (87%). Complete comments are included in Appendix 2.

- “Not obvious there is any”
- “Many patients on Remicade® have no insurance and this would leave them without drug”
- “Excellent control and levels on initial biologic on a difficult to control patient; I would NOT risk switch in this circumstance”
- “Should likely follow previous studies - patients should be medically stable”
- “Someone who has already had dose optimization of the biologic, or is on a "fine line" for maintaining response should not be switched - someone who is in induction or just finishing or just in the first 1 to 2 years of being on the biologic should not be switched - someone who you just managed to optimize and get drug levels good and into remission should not be switched - someone who it is their 2nd or 3rd line biologic already - should not be switched”

Participants offered specific comments on the paediatric population:

- "I think we are still lacking paediatric data and I worry about the immunogenicity of anti-TNFs. Moreover we have less options for biologics in children. I think we should use biosimilars but do not feel so confident about switching once a patient is established"
- "I think there is insufficient evidence to transition pediatric patients from Remicade to inflixmab biosimilars. They have such a long life ahead, and there are few other alternative therapies available. If they develop anti-drug antibodies, it has very long-term consequences. In my view, that risk is too great."

Three gastroenterologists with scientific and clinical experience in treating paediatric patients with IBD offered the following:

- "I do not accept that there is currently sufficient evidence that demonstrates NO increased risk of loss of effect in paediatric aged IBD patients receiving Remicade who switch to the biosimilar Renflexis. There is reasonable evidence/data that highlights the PK/PD of infliximab in Paediatric aged patients has important differences from adult patients, and the basis of these differences is currently poorly understood and, thus, their effect difficult to predict. I am also anxious that acceptance of such an approach (switching between infliximab molecules in this case from the originator to one of its biosimilar molecules) positions us, going forward, to encounter the scenario of multiple switches between infliximab's originator and biosimilar molecules as any of the currently approved 3 molecules becomes cheaper than the other 2 options.

  In the event of forced switch I believe it is important to have access to tools that allow for the close monitoring of each patient during the switch, ongoing surveillance for possible long-term reductions in effectiveness, and ensuring, following the switch, that patients and their health care teams have access to a 'product' that is truly 'similar' to the Remicade they are currently on (that includes ongoing long-term access to monitoring, compassionate drug, patient support, administrative co-ordination etc)." (Dr. Thomas Walters, University of Toronto, Paediatrics, Hospital for Sick Children, Toronto, ON: personal communication, July 28, 2019)
- [Prior to a policy for children who have been stable on Remicade to switch to its biosimilar], "I would first like to gain experience using the drug with new starts. I would also include fecal calprotectin for monitoring and the ability to appropriately dose adjust based on trough levels. I would also suggest the inclusion of an appropriate monitoring strategy to determine the safety, efficacy and effectiveness of this cost saving strategy." (Dr. Kevan Jacobson, University of British Columbia, British Columbia's Children's Hospital and British Columbia Children's Hospital Research Institute, Vancouver, BC: personal communication, July 26, 2019)
- "I am comfortable switching children who have been stable on Remicade to its biosimilar. The supports or considerations that need to be ensured for pediatric IBD patients include Pediatric Infusion Center Standards, serum trough levels, easy access without so much process, and the ability to easily optimize therapy for individual

patients." (Dr. David Mack, University of Ottawa, Children's Hospital of Eastern Ontario, Ottawa, ON: personal communication, July 26, 2019)

Four gastroenterologists with scientific and clinical expertise in treating pregnant patients with IBD were unanimous in their recommendation that these patients should be a medical exception.

- "I would not do it in a pregnant patient. There is too much to lose even if there is a remote possibility of a flare in someone who was doing fine on their originator. Wait until after they deliver to switch." (Dr. Geoff Nguyen, University of Toronto, Institute for Health Policy Management and Evaluation, Mount Sinai Hospital, Toronto, ON: personal communication, 2019 Jul 17)
- "Pregnancy is a period of time where patients and providers are hyper anxious and aware of the impact of IBD and its associated therapeutics on the mother and fetus. If there is no known medical benefit (and a potential disadvantage in terms of possible destabilization of disease) I don't think it is fair or advisable to enforce this switch. It can already be a challenging conversation to encourage patients to remain on their current therapeutics while pregnant." (Dr. Natasha Bollegala, Women's College Hospital, University of Toronto, Toronto, ON: personal communication, 2019 Jul 17)
- "Would not risk the chance of any adverse outcomes due to switching. On a scientific query since they are biosimilars and glycosylation etc could be slightly different, do we even know to that level the "safety" of biosimilars in pregnancy?" (Dr. Vivian Huang, University of Toronto, Mount Sinai Hospital, Toronto, ON: personal communication, 2019 Jul 17)

Commentary

Participants were asked to offer any additional comments on the subject of non-medical switching. A range of comments were received including questions about transitioning infusion centre sites and the responsibility surrounding that (5%) as well as specific comments about the importance of doctor/patient decision-making (20%). Complete comments are included in Appendix 2.

- "The cost savings does not seem sufficient to warrant the change. Recently, I have found that more Inflectra® is required to have a benefit for new starts. If you have to give more drug, then cost savings are no longer there."
- "This should not be done as patients receive more than just drug from current support programs that benefit their care"
- "Based upon European experience in the past 4yrs with biosimilars of Infliximab, I do not anticipate concerns. Reduced cost will benefit all Canadians"
- "While I understand the logistics, I do not feel this should be an enforced switch, especially for patients in deep remission."
- "Currently Remicade® can be given to patients with full financial support, many cannot afford biosimilars - might be possible to switch if full coverage"

- “One time switch may be okay - but we are waiting for more scientific evidence…..multiple switching (depending on the "govt of the day" may not be good…..it is not as simple as just switching a drug - there is an entire logistics and support that goes with the drug delivery - patient support program, which infusion clinics, monitoring tools”
- “CAG also needs to encourage initial start of biosimilars, not just switching for patients with IBD who require TNFs. Information presented to clinicians and patients needs to be presented in a evidence based and unbiased manner”

Follow up questions to 30 gastroenterologists across Canada indicated that most (80%) would not switch patients from an innovator biologic to its biosimilar unless there was a specific payer mandate to do so.

IBD Nurses

Participants

Of the IBD nurses surveyed, 44% were from Ontario, 27% were from Alberta, 12% were from British Columbia, 10% were from Québec and 2% from Manitoba, New Brunswick and Nova Scotia. Other provinces and territories did not have any IBD nurse respondents. The majority of participants (80%) reported more than 100 patients with Crohn’s and ulcerative colitis in their practice. Most IBD nurse participants reported that their practice was in a major academic centre (68%).

Safety and Effectiveness

IBD nurse participants agreed (82%) that biosimilars offer safe and effective treatments for people with IBD (Figure 9). When asked if a one-time switch from the infliximab biologic Remicade® to the biosimilar Inflectra® or Renflexis® was safe and effective 50% agreed, 27% disagreed and 23% required more information on biosimilars to answer (Figure 10).

Figure 9 – Biosimilars Offer Safe and Effective Treatment

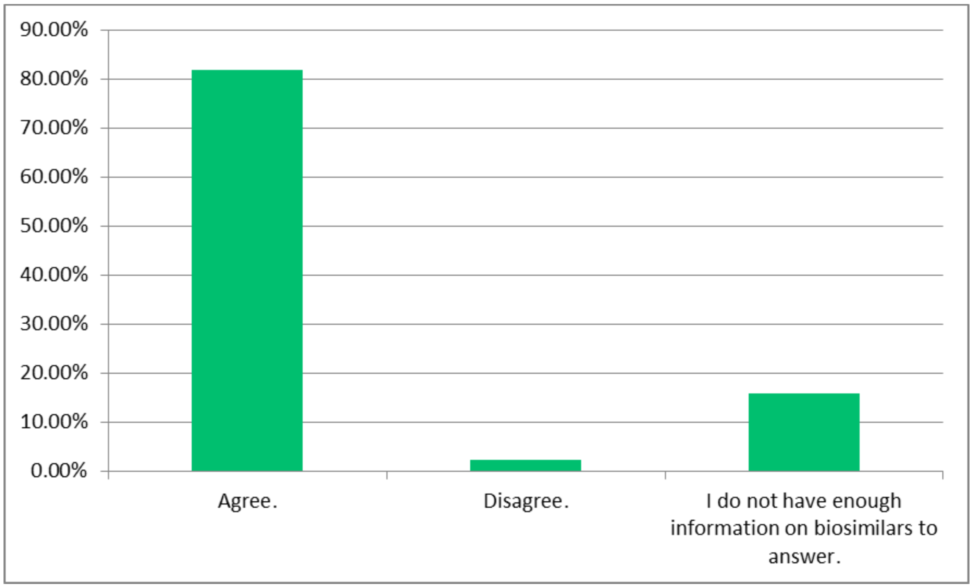
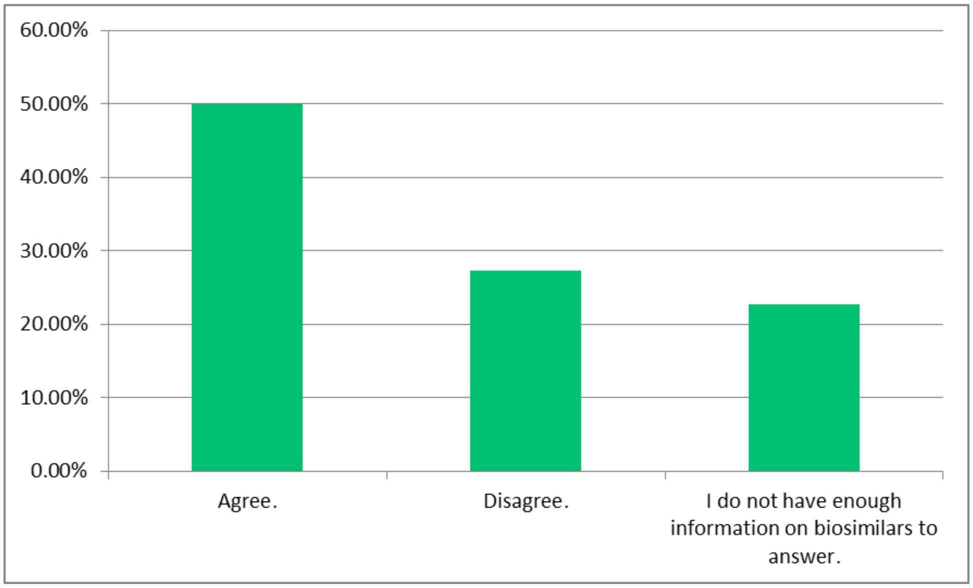


Figure 10 – One-Time Switch From Innovator Biologic to Biosimilar Is Safe and Effective



Required Patient Support

IBD nurses who responded to the survey agreed that should a one-time switch policy from the infliximab biologic Remicade® to the biosimilar Inflectra® or Renflexis® be enforced, they would require a number of supports for their patients including information pamphlets, an infoline to which they may refer patients, and a dedicated telephone number for patients to receive information.

Additional support suggested by 12 comments from participants included dedicated staff, financial information and support, psychological support and surveillance of outcomes as well as education for health care practitioners. Complete comments included in Appendix 2.

- "Compassionate drug availability, patient support (access, info, drug levels), easy access with support nurses, clinic support (blood draws etc) i.e. provide services similar to what we have with originators"
- "Education for practitioners and more research on efficacy"
- "Data collection to assess for adverse events"
- "Useful patient support program and safe infusion centres"

Medical Exceptions

IBD nurse participants were asked to consider the circumstances that would cause them to consider that a patient is medically unable to transition to a biosimilar from the innovator biologic. From the range of responses received, 54% suggested that patients with difficult to control disease may be an exemption, 9% indicated that they considered that there were no circumstances in which a patient could not be switched, and 8% were unsure of these circumstances. Complete comments are included in Appendix 2.

- "Very few"
- "I think the patient would need to be >3 years in full remission before a patient should be switched"
- "I don't work in a prescribing environment, however I would be concerned if the patient has had difficulty maintaining symptom control in the past."
- "Reliant on an aspect of support service such as compassionate dosing. Good relationship with support service. Fragile disease. Reliance on a particular infusion site."

Participants offered specific comments on the paediatric population:

- "I work with a pediatric population , not enough evidence based studies to support"
- "Because of the pediatric population , we feel hesitant to use the biosimilars because of the lack of sufficient evidence based practice."

Commentary

Participants were asked to offer any additional comments on the subject of non-medical switching. A range of topics were covered from among 12 comments. Complete comments are included in Appendix 2.

- “Finances should not be what is determining what medication the patient is using. If a patient is currently on a prescribed medication, and this medication is effective, the patient nor the physician should be forced to change therapies to a biosimilar. From a patients perception - will this lead to stress/anxiety leading up to switch….”
- “Savings realized should benefit the IBD health care funding envelope”
- “The discussion with individuals that are being considered for switch need to be informative, supportive and thoughtful.”
- “No reason not to switch
- I don't agree with switch program - risk of loss of remission and no other therapies. Why not new starts only applied to biosimilar?”

Patients and Caregivers

Participants

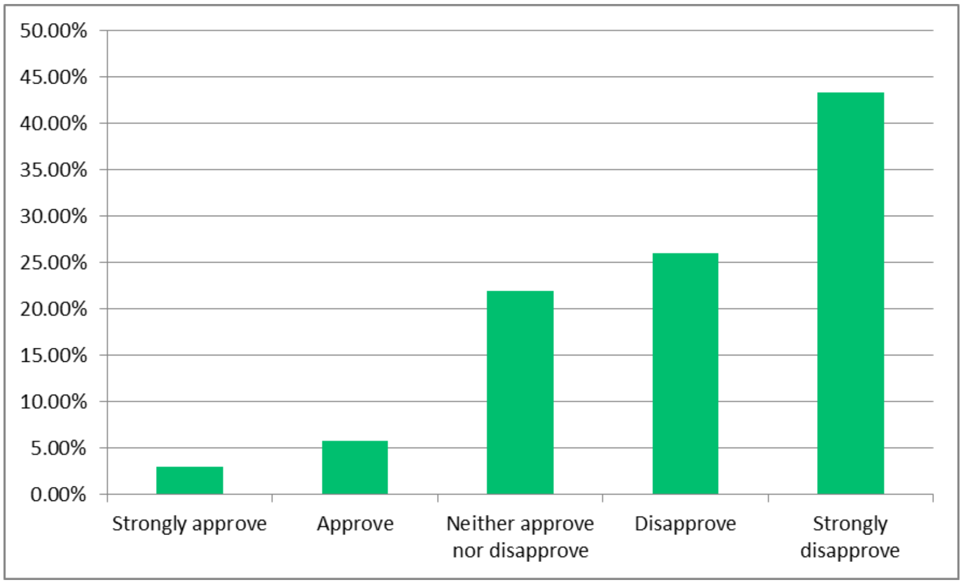
Of the patient and caregivers surveyed, 42% were from Ontario, 11% were from Alberta, 10% were from British Columbia, 24% were from Québec, 4% from Saskatchewan and 3% from Manitoba, New Brunswick and Nova Scotia. A few responses were received from Prince Edward Island, Newfoundland and Labrador and Northwest Territories. No responses from patients or caregivers were received from Yukon or Nunavut. The majority of participants (71%) reported living in an urban area and most (85%) identified as a patient. A good representation of patient age groups was received, with most identifying as 36-60 years old (50%) or 18-35 years old (37%). The vast majority of participants indicated that they or their loved one was currently or had been treated with a biologic or biosimilar (89%).

Awareness

Patient and caregiver participants were asked if they had any awareness of potential policy changes that would indicate switching from current innovator biologic treatment to a less costly (biosimilar) treatment. Responses were mixed; 40% indicated that they had heard about such a policy, 58% indicated that they were not aware of any potential switching policy and a few indicated that it did not apply to them or the person they cared for.

Patients and caregivers were asked generally how they felt about such a potential policy change. Responses (Figure 11) ranged from strongly disapprove (43%), disapprove (26%) to approve (6%) or strongly approve (3%). Several participants indicated that they were neither approved or disapproved (22%).

Figure 11 – Patient consideration for policy change involving switching from innovator biologic to biosimilar



Required Patient Support

Patients and caregivers who responded to the survey agreed that should a one-time switch policy from the infliximab biologic Remicade® to the biosimilar Inflectra® or Renflexis® be enforced, they would require a number of supports including additional and dedicated appointments/follow up with gastroenterology specialists and nurses, detailed education and communication, and financial information and support. Many participants expressed vehement opposition to a change in their treatment in response to this question, with some predicting dire health care requirements, while others indicated a lack of understanding as to what a switch policy would imply. Hundreds of comments and suggestions were received; from among these 61% suggested meetings with their health care specialists together with careful follow-up if a switch was initiated, 6% expressed a need for more information, 6% indicated confusion or inability to answer and 5% suggested financial support and information. Complete comments are included in Appendix 2.

- “Clinic visits and follow up with GI team; additional follow up appointments to track response; potentially additional procedures/tests to evaluate any changes (scopes, etc).”
- “Just ensure my husband can still access a place to get his medication”
- “I have no idea. If it ends up working, nothing more than I already have.”
- “More information. I'm in remission while on Remicade®, what happens if I am forced to switch and go into a Crohn's flare?”
- “Knowledge about new drug, how it will affect me, what do do if it doesn't work for me (ie. can I go back to my biologic?)”

- "If the new drug doesn't keep her in remission it's a huge cost to her health and the healthcare system"
- "New financial help as the drug company itself covered the remainder of my medication cost since I couldn't afford it. Any new drug that costs anything for me would hit my low income budget. I would also need help getting medical leave from my work to deal with the change and help paying the expenses to visit my doctor two hours away more regularly while switching over."
- "Remicade® finally has me stable and in remission. I have not missed work, I can participate fully in my work and family life, I have not been hospitalized since being on Remicade®. To imagine going back to frequent doctor visits, hospitalization and being sick is horrible."
- "Maybe for new patients. Not for people that are already on a drug that has put them into remission."
- "I would probably need surgery or not be able to work any longer."

Commentary

Participants were asked to offer any additional comments on the subject of non-medical switching. Hundreds of comments were received, most quite passionate, personal and pointed. From the comments received from patients and caregivers, 50% explained the agonizing journey to achieve remission and expressed anxiety, concerns and objections to a switch policy, 11% suggested that decision-making must be between the patient and specialist, 10% commented on lack of information, and 6% discussed financial implications. Some responses highlighted the need for education of patients and caregivers as to the treatments available for IBD. Complete comments are included in Appendix 2.

Actual responses included the following:

- "I feel as though people should have a say in whether they switch or not. And there should be an appropriate protocol for switching back if the new medication doesn't function as well."
- "If it works: support! Physicians should be careful not to make the error of believing everyone will see the same outcome."
- "If it's less expensive and equally effective I would have no problem switching drugs."
- "The medical requirements for an individual should be determined by the attending physician and patient."
- "Remicade has made a huge difference for me. I'm now able to live my life most days without fear of having an accident and without being in excruciating pain from all the inflammation in my body. If I were suddenly denied this or forced to switch, I fear it would have catastrophic consequences on my body."
- "I think starting new patients on a bio similar is feasible but there is absolutely no way a successful treatment program should be switched. The risk of remission is too high. Also, quality of life is precarious even with successful treatment - it is not fair to ask patients currently on biologics to make a switch."

- “There is sufficient amount of research that’s been done to warrant a switch. From my readings I’ve heard that biosimilars are not as effective.”
- “Would like to learn more about this potential switch to bio similar treatments.”
- “I live in fear I will no longer qualify for assistance and not get medicine. I am afraid I'll be on this the rest of my life.”
- “Psychological effects need to be considered. Efficacy of medication is improved, in my opinion, when the patient believes in the medication he is given.”
- “I’m terrified of switching to a bio similar and flaring. I would definitely need psychological help for stress and anxiety due to worry about flaring. During a flare I would need many appointments with my GI in person and GI Nurse over the phone. My quality of life is barely acceptable and I’m borderline suicidal as it is.”

DISCUSSION

This study sought to ascertain the perspectives of key stakeholders including gastroenterologists, IBD nurses and patients and caregivers as they relate to a non-medical biosimilar switch policy for patients with IBD.

Generally, the results indicate that gastroenterologists and IBD nurses agree that biosimilars offer safe and effective treatment for patients with IBD. A one-time switch for patients with IBD from an innovator biologic to a biosimilar however was not overwhelmingly considered acceptable among gastroenterologists and IBD nurses (just over 50% agreed). The remaining gastroenterologists and IBD nurses were split among considering this unacceptable and requiring further information.

Both groups had common suggested exemptions should a policy change be initiated that included pregnant and paediatric patients. Further, gastroenterologists and nurses suggested exemptions even if they agreed with a one-time switch. Both gastroenterologists and IBD nurses were firm that patients must be stable prior to a switch and that patients who are not in remission or have disease that is difficult to control should be exempt. Financial concerns for their patients including loss of compassionate coverage as a result of a switch were expressed by both gastroenterologist and IBD nurse respondents.

Opportunities exist to provide information and education on biosimilars among both health care groups. More than 20% of these participants felt that they required additional information on the topic.

While this study was not intended to represent all gastroenterologists and IBD nurses across Canada, a general understanding of the perceptions of gastroenterologists and IBD nurses on the topic of biosimilar switch policy may be drawn. The mixed responses received indicate a stakeholder group without an overwhelming consensus, and therefore may provide significant barriers to policy implementation.

Contrastingly, and demonstrating a significant divide, patients and caregivers surveyed were generally against a non-medical switch and expressed vehement and emotional opposition. This stakeholder group provided valuable information on the realities of the complex treatment for IBD and the individual challenges that are faced due to these chronic diseases. An exceptional number of patients and caregivers detailed the number of years in ill-health and financial straits prior to achieving remission and expressed palpable anxiety over their potential loss of quality of life should a non-medical switch affect their disease stability.

Barriers to switching that were identified through this study must be addressed carefully through dedicated education, communication and significant support.

The theme across all stakeholder groups was education and communication. This includes basic information about biosimilars and innovator biologics, and also clarity around implications of a switch policy including financial, psychological and physical.

Patients and caregivers, gastroenterologists and IBD nurses are a critical source of information for decision makers on a non-medical biosimilar switch policy.

APPENDIX 1 – SURVEYS

Gastroenterologist Survey

In 2016, there was general consensus amongst the inflammatory bowel disease (IBD) scientific and medical community that patients in remission being treated with an innovator biologic should not be forced to switch to a biosimilar. At that time, it was considered that there was insufficient scientific evidence to show that patients responded as well to a biosimilar when switched from the innovator biologic. Since then, new international evidence that may or may not be applicable to the Canadian environment has accumulated and provincial jurisdictions (and private payers) are considering policy changes that will affect patients with IBD.

Crohn's and Colitis Canada is revisiting our position on biosimilars. Along with our own internal review of the latest international evidence and its applicability to Canada, we need your critical input to determine how and if our position should change.

Please complete the following short survey by **Thursday July XX, 2019**. It will only take **5 minutes** of your time. If you wish to discuss this issue in detail or if you have any questions about the survey, please contact: help@crohnsandcolitis.ca

1. My practice is in the following jurisdiction:

   ☐Alberta
   ☐British Columbia
   ☐Manitoba
   ☐New Brunswick
   ☐Newfoundland-Labrador
   ☐Northwest Territories
   ☐Nova Scotia
   ☐Nunavut
   ☐Ontario
   ☐Prince Edward Island
   ☐Quebec
   ☐Saskatchewan
   ☐Yukon

2. The number of patients with Crohn's and ulcerative colitis treated in my practice is approximately:

   ☐ 1-15
   ☐ 16-50
   ☐ 51-100

☐ >100

3. My practice is at a major academic centre.
   ☐ Yes
   ☐ No

4. Biosimilars offer additional safe and effective treatments for people with IBD.

   ☐ Agree
   ☐ Disagree
   ☐ I do not have enough information on biosimilars to answer.

5. There is sufficient scientific evidence to show that patients respond as well to the biosimilar when switched from an innovator biologic.
   ☐ Agree
   ☐ Disagree
   ☐ I do not have enough information on biosimilars to answer.

6. A one-time switch from the infliximab biologic Remicade to the biosimilar Inflectra or Renflexis is safe and effective (acceptable).

   ☐ Agree
   ☐ Disagree
   ☐ I do not have enough information on biosimilars to answer.

7. Should a one-time switch policy from the infliximab biologic Remicade to the biosimilar Inflectra or Renflexis be enforced, what needs to be in place to ensure the health and well-being of your patients? [multiple selections allowed]
   ☐ Information pamphlets
   ☐ Infoline that I can refer the patients to
   ☐ Support line
   ☐ Other
     [open text]

8. Should a one-time switch policy from the infliximab biologic Remicade to the biosimilar Inflectra or Renflexis be enforced, what circumstances would cause you to determine that a patient is medically unable to transition to a biosimilar drug (switch)?

   [open text]

9. Please share any additional comments you may have.

[open text]

END MESSAGE
Thank you for completing this survey. Your input is very valuable to us and will contribute to an updated Crohn's and Colitis Canada position statement on biosimilars. If you have any questions or further comments, please contact help@crohnsandcolitis.ca

IBD Nurse Survey

In 2016, there was general consensus amongst the inflammatory bowel disease (IBD) scientific and medical community that patients in remission being treated with an innovator biologic should not be forced to switch to a biosimilar. At that time, it was considered that there was insufficient scientific evidence to show that patients responded as well to a biosimilar when switched from the innovator biologic. Since then, new international evidence that may be or may not be applicable to the Canadian environment has accumulated and provincial jurisdictions (and private payers) are considering policy changes that will affect patients with IBD.

Crohn's and Colitis Canada is revisiting our position on biosimilars. Along with our own internal review of the latest international evidence and its applicability to Canada, we need your critical input to determine how and if our position should change.

Please complete the following short survey by **Thursday July XX, 2019**. It will only take **5 minutes** of your time. If you wish to discuss this issue in detail or if you have any questions about the survey, please contact: help@crohnsandcolitis.ca

1. I practice in the following jurisdiction:

   ☐Alberta
   ☐British Columbia
   ☐Manitoba
   ☐New Brunswick
   ☐Newfoundland-Labrador
   ☐Northwest Territories
   ☐Nova Scotia
   ☐Nunavut
   ☐Ontario
   ☐Prince Edward Island
   ☐Quebec
   ☐Saskatchewan
   ☐Yukon

2. The number of patients with Crohn's and ulcerative colitis treated in my practice is approximately:

   ☐ 1-15
   ☐ 16-50
   ☐ 51-100
   ☐ >100

3. I work at a [multiple selections allows]:
   ☐ major academic centre
   ☐ community clinic
   ☐ Infusion clinic
   ☐ Other
   [Open text for OTHER]

4. Biosimilars offer additional safe and effective treatments for people with IBD.

   ☐ Agree
   ☐ Disagree
   ☐ I do not have enough information on biosimilars to answer.

5. A one-time switch from the infliximab biologic Remicade to the biosimilar Inflectra or Renflexis is safe and effective (acceptable).

   ☐ Agree
   ☐ Disagree
   ☐ I do not have enough information on biosimilars to answer.

6. Should a one-time switch policy from the infliximab biologic Remicade to the biosimilar Inflectra or Renflexis be enforced, what needs to be in place to ensure the health and well-being of your patients? [multiple selections allowed]
   ☐ Information pamphlets
   ☐ Infoline that I can refer the patients to
   ☐ Support line
   ☐ Other [open text]

7. Should a one-time switch policy from the infliximab biologic Remicade to the biosimilar Inflectra or Renflexis be enforced, what circumstances would cause you to consider that a patient is medically unable to transition to a biosimilar drug (switch)?

   [open text]

8. Please share any additional comments you may have.

   [open text]

Thank you for completing this survey. Your input is very valuable to us and will contribute to an updated Crohn's and Colitis Canada position statement on biosimilars. If you have any questions or further comments, please contact help@crohnsandcolitis.ca

Patient/Caregiver Survey

You may be aware of current news that has mentioned biosimilar drugs in the treatment of people with inflammatory bowel disease. Biosimilar drugs (e.g. Inflectra or Renflexis) are highly similar to their innovator biologic drug (e.g. Remicade), but not exactly the same. A few years ago, there was not enough research to conclude that patients in remission being treated with an innovator biologic could safely and effectively switch to a biosimilar. Since then, evidence from international sources (potentially applicable to Canadian patients) has accumulated and provincial jurisdictions (and private payers) are beginning to reconsider such a switch.

Crohn's and Colitis Canada is revisiting our position on biosimilars. We will be considering a lot of information as we determine if our position should change, including your input as a person or caregiver living with inflammatory bowel disease.

Please complete the following short survey by **Thursday July XX, 2019**. It will only take **5 minutes** of your time. If you wish to discuss this issue or if you have any questions about the survey, please contact: help@crohnsandcolitis.ca

1. I live in the following province or territory:

   ☐Alberta
   ☐British Columbia
   ☐Manitoba
   ☐New Brunswick
   ☐Newfoundland-Labrador
   ☐Northwest Territories
   ☐Nova Scotia
   ☐Nunavut
   ☐Ontario
   ☐Prince Edward Island
   ☐Quebec
   ☐Saskatchewan
   ☐Yukon

2. I live in a major urban area.
   ☐ yes
   ☐ no

3. I am a:
   ☐ patient
   ☐ caregiver

4. Patient Age:

   ☐ 1-17
   ☐ 18-35
   ☐ 36-60
   ☐ >61

5. Are you (or your loved one) currently being treated with a biologic or biosimilar (Humira®, Remicade®, Inflectra®, Renflexis®, Stelara®, Entyvio®, Simponi®). Or were you treated with a biologic or biosimilar in the past?
   ☐ Yes
   ☐ No
   ☐ I don't know

6. I have heard that patients with Crohn's or ulcerative colitis may be told to switch from their current treatment to a less costly treatment sometime in the future. (e.g. switch from Remicade to Inflectra or Renflexis).

   ☐ Yes, I have heard about this
   ☐ No, I have not heard about this
   ☐ Not applicable to me or the person I care for.

   How do you feel about this?
   [open text]

7. Should a switch from your current treatment to another be enforced by your provincial or private payer where you live, what supports would you need? (e.g. special counselling from gastroenterologist; meeting with GI nurse; other).

   [open text]

8. Please share any additional comments you may have.

   [open text]

Thank you for completing this survey. Your input is very valuable to us and will contribute to an updated Crohn's and Colitis Canada position statement. If you have any questions or further comments, please contact
help@crohnsandcolitis.ca

APPENDIX 2 – FULL STAKEHOLDER COMMENTARY

Gastroenterologist Comments – Additional Support

I need to directly contacted and have a dedicated coordinator to facilitate re-reimbursement issues and care implications
Dedicated biologic coordinator with nursing background
smooth transition as they will be 2 different patient support programs and 2 different companies etc
no, this should be a decision made between the patient and physician
A patient support program for the biosimilar, just as good as there is for the innovator drug
I don't approve of a mandated switch
Patients need to given the option to switch not forced to do so
It should be accepted that Remicade cost is dropped to same as biosimilar and leave patient on original drug
Financial support to patients that do not do well.
clear explanation of cost reasons for switching also we need adequate guarantees that infusion locations will be in place
There is a potential for significant psychological impact on the patient regardless of what the evidence states. This neseccitates a honest and informed discussion between the care provider and the patient. Logistically, if this was enforced it would take a significant amount of resources to do this right especially if you are a large prescriber of biologic therapy
Complex question, ideally multiple supports would be available - those mentioned above & more personalized resources w/in expert centers/ clinics
Surveillance outcomes and infusion centers publicly supported
Combination of pamphlets and support line, the 2nd for the 30% of Canadians who are functionally illiterate.
more evidence in paediatrics
Information needs to be clear and unbiased.

Gastroenterologist Comments - Consideration of Patients Medically Unable to Switch

History of anti-drug antibodies
I don't have enough data about immunogenicity and differences that may trigger lack of response
Still trying to find the right drug level, patient flaring while on drug, issues with antibodies
none that i can think of at present
Not obvious there is any
none that i can think of at present
This is a difficult question to answer, mostly out of concern based on limited information. While I suspect many if not most (even perhaps all) may be able to switch adverse event

(primarily loss of efficacy) there is still a concern based on limited data at this time. Certainly if a patient had a significant course prior to achieving remission, then I would be hesitant 'to roll the dice' even if it is relatively weighted.
Patient preference. Patient insured.
if they are receiving compassionate drug
Pt preference
Many patients on remicade have no insurance and this would leave them without drug
See above, during transition to adult care, patients with anxiety, ? hospitalized patients with acute severe disease (as limited evidence currently available)
He has had a difficult disease to control and achieve remission.
Well patient after difficult time and meds to establish the well state
Patient that took a long time to stabilize and have minimal other options if drug fails
1-Patient dont la mise en rémission a été difficile après un traitement par Remicade , 2-Patient en phase d'induction en cours de traitement par Remicade.
Excellent control and levels on initial biologic on a difficult to control patient; I would NOT risk switch in this circumstance
High risk disease
Si l'ajustement des niveaux sériques est en cours. Multiples échecs antérieurs à d'autres classes de biologiques.
History of difficult to control disease
If the patient has had difficult to control disease
I don't think there would be a situation where a patient is "medically unable" to transition but it would seem to be reasonable to only consider it in patients who are in stable remission, however one defines that, and only in patients where Remicade is their first anti-TNF agent.
During induction or active optimization... ideally when stable
patient that may be losing response
loss of response, patient should have stable disease
Pts en remission partielle
Not sure. I would prefer to get them into remission first
Should likely follow previous studies - patients should be medically stable
Someone not in stable remission
Patient not in remission on innovator drug, based on endoscopic assessment of mucosal healing OR fecal calprotectin
- someone who has already had dose optimization of the biologic, or is on a "fine line" for maintaining response should not be switched - someone who is in induction or just finishing or just in the first 1 to 2 years of being on the biologic should not be switched - someone who you just managed to optimize and get drug levels good and into remission should not be switched - someone who it is their 2nd or 3rd line biologic already - should not be switched
Medical stability - I disagree with switching.
doing well on remicade

Absence de centre de perfusion de l'autre compagnie dans sa région.
Location of different infusion clinic may present difficulties for patients.
Achievement of disease remission after failure of multiple other drugs may produce a psychological attachment to the effective drug.
I think we are still lacking paediatric data and I worry about the immunogenicity of anti-TNFs. Moreover we have less options for biologics in children. I think we should use biosimilars but do not feel so confident about switching once a patient is established
Pediatrics cases, more complicated cases with history of LOR to previous medications or primary non-response
Grossesse

Gastroenterologist Comments – Additional

I think there is insufficient evidence to transition pediatric patients from Remicade to inflixmab biosimilars. They have such a long life ahead, and there are few other alternative therapies available. If they develop anti-drug antibodies, it has very long-term consequences. In my view, that risk is too great.
Le passage du biologique novateur au bio similaire est généralement sécuritaire mais il y a tout de même dans les études un petit pourcentage de perte de réponse, ce qui m'amène à prendre position contre un passage obligatoire au bio similaire.
No additional comments. Switch is only being done for cost containment purposes. Government and private insurers should allow for fair market pressures and if innovator drugs come in and drop their price to that if the biosimilar this should be allowed and should be made transparent.
The cost savings does not seem sufficient to warrant the change. Recently, I have found that more Inflectra is reqd to have a benefit for new starts. If you have to give more drug, then cost savings are no longer there.
Biosimilars should be priced at 25-50% [maximum] of market cost of original agents. Products priced higher should not be accepted for provincial plans.
Although biosimilars IFX are effective and safe, they are certainly not better than the originator. No reason to switch unless obliged to do so. No reason to be obliged unless the government can prove cost savings and what they will do with the money saved.
This should not be done as patients receive more than just drug from current support programs that benefit their care
Based upon European experience in the past 4yrs with biosimilars of Infliximab, I do not anticipate concerns. Reduced cost will benefit all Canadians
Europe is way ahead of us and have already paved the way with many of our "fears" being allayed
Unfortunately, I feel that the similarity between Biologics and bioequivalents is simply the result of statistical manipulation
The ultimate decision should be in the hands of the physician and patient not policy makers
While I understand the logistics, I do not feel this should be an enforced switch, especially for patients in deep remission.

beware forced switching
Every effort should be made not to have politics demand therapy changes
the health system needs to have a sufficient number of infusion sites Not sure if in the longer run pharmaceutical companies will continue to support that Paperwork is substantial also for monitoring we need adequate allied health professional supports
What is to be done with all the extra free drug doses from J&J that many patients are receiving. Are the bio similar produces going to match this program of extra dosing or higher dosing of in-patient UC patients, as BC Pharmacare is rejecting these requests.
Who will provide and pay for the infusion center support currently provided by industry? Shifting costs to hospitals is unreasonable.
At present Janssen and Abbvie provide a great deal of compassionate drug both to start and optimize treatment. The biosimilar companies have not been willing to do this.
currently remicade can be given to patients with full financial support, many cannot afford biosimilars - might be possible to switch if full coverage
The current system is unaffordable. Switch is inevitable & has been effectively cost avoidant in many other jurisdictions safely. Its crazy to think this wont be a wide soread phenom in canada and it will help to push better price controls
one time switch may be okay - but we are waiting for more scientific evidence   multiple switching (depending on the "govt of the day" may not be good   it is not as simple as just switching a drug - there is an entire logistics and support that goes with the drug delivery - patient support program, which infusion clinics, monitoring tools (e.g. TDM, FCP, dashboard) etc etc
I too was not in favour of an automatic switch program initially, but believe there is now enough cumulative data to make a switch acceptable if it will help save significant costs to public health care.
CAG also needs to encourage initial start of biosimilars, not just switching for patients with IBD who require TNFs. Information presented to clinicians and patients needs to be presented in a evidence based and unbiased manner
D abord respect des pts et d ailleurs tous les biologiques anti TNF ont une duree d efficacite limitee dans le temps,pourquoi ne pas attendre ce moment puis agir selon les circonstances cliniques(anti tnf encore ou switch)
Travailler intéressant. Nous serons heureux de voir les résultats de cette enquête

IBD Nurse Comments – Additional Support

current patient support program for biosimilar is not equipt to hand rapid influx. physicians are reporting from their experience the response to the biosimilar inflectra is not as effective therefore they are not supporting an automatic switch due to insurance providers requests as the physicians are responsible for the patient's health, not the insurance providers review boards
full details of insurance policy if switch is not effective
what happens when a person switches and then fails? who takes responsibility, the insurer?
website
compassionate drug availability, pt support (access, info, drug levels), easy access with support nurses, clinic support (blood draws etc) ie provide services similar to what we have with originators
lots of information & support system
education for practitioners and more research on efficacy
Useful patient support program and safe infusion centres
Guided support
i do not support switch but patients need support and currently there is not a phone support line available to deal with patient's concern
data collection to assess for adverse events
long term evidence base studies

IBD Nurse Comments – Consideration of Patients Medically Unable to Switch

This would be at the discretion of the ordering physician.
None.
none
none
Very few.
IBD clinical course, marker levels (CRP, FCP), courses of steroids
unsure
Unsure
??
previous antibody formation on alternate biologic therapy;
Severe disease and in remission with remicade.
patients need to be in full endoscopic and clinical remission with adequate drug levels before a switch would be appropriate
I think the patient would need to be >3 years in full remission before a patient should be switched
patient not in documented deep remission, on remicade less than 5 years?
Pt is not in remission, pt does not want to switch

They are not yet currently stable on the treatment
I don't work in a prescribing environment, however I would be concerned if the patient has had difficulty maintaining symptom control in the past.
Active symptoms
active disease
difficult case
Severe patient that was difficult to put into remission
someone who has been very ill and difficult to get into remission
severely ill pts in the process of starting treatment with one or other molecule
A one time switch has evidence to support safety. The cost savings to the system are relevant and important. There are no medical indications not to switch but there could be psychological
Reliant on an aspect of support service such as compassionate dosing. Good relationship with support service. Fragile disease. Reliance on a particular infusion site.
High dose and frequent infusion visits. Many extra manifestations. Tried several other biologics. Receiving a compassionate drug from pharma
Accessibility
Patient refusal
Patient refusal
Current status of disease, patient concerns
pt currently in remission with Remicade and is final approved biologic therapy for that pt - they have failed all others to date
have failed 2 or more biologics in the past
1. Patients has an autoimmune response to infliximab 2. No clinical response to Remicade 3. Severe adverse reactions to Remicade and/or history of serious infections (including TB, fungal infections etc) and/ or history of Lymphoma or other types of cancer
I don't agree with switching any patients to a biosimilar. I believe we are putting our patients at risk with the possibility of developing antibodies or loss of response.
high risk patient with hx of surgery, early onset disease, steroid dependency, fistulising disease
i work with a pediatric population , not enough evidence base studies to support .
Not if patient is not in remission, not if classified as high risk for recurrence of disease, paediatric patients should not be switched, not if patient has failed another biological

IBD Nurse Comments - Additional

Finances should not be what is determining what medication the patient is using. If a patient is currently on a prescribed medication, and this medication is effective, the patient nor the physician should be forced to change therapies to a biosimilar. From a patients perception - will this lead to stress/anxiety leading up to switch, what will happen if the biosimiliar for that patient ends up not being as effective as the originally prescribed medication? do we then risk switching back to the original? will insurance providers allow coverage? It is messy!!! A patient should stay on the originally prescribed medication. we have seen this with generic

medications already - the "generic" or similar medication is NOT as effective, but insurance will only cover the "less costly" medication despite it not being what is effective for the patient.
supports need to be provided, if they are not, then I think the savings need to be greater than those at present (~50%). The value adds with originator molecules make ease of access and care for our IBD its better. These value adds trump the potential savings at present, I feel
Savings realized should benefit the IBD health care funding envelope.
The discussion with individuals that are being considered for switch need to be informative, supportive and thoughtful. The comments from patients on the CCC website would suggest this is not being done well at this time.
The service offered by biosimilar compagnies has been mediocre. Before forcing a switch, they should be forced to offer a good quality service to patients and physicians otherwise it will negatively impact patient care
Quality of services offered by jansenn is way above the other two (ex, follow up, availiabity of blood work up, blood levels of infliximab, calprotectin)
Get originals to lower price
No reason not to switch
From the switch patients that we have seen ie. travellers or pts who moved from the UK, they have had no issues at all with it.
While I believe that biosimilars are as effective, I do not feel that patients should be forced to switch.
I don't agree with switch program - risk of loss of remission and no other therapies Why not new starts only applied to biosimilar
because of the pediatric population , we feel hesitant to use the biosimilars because of the lack of sufficient evidence based practice .

Patient and Caregiver Comments – Additional Support

Besoin d'un rendez-vous avec un gastroentérologue et l'assurance que les résultats sont identiques
100% I would be talking to my gastro. There's no way I would be willing to switch if what I'm on is working. If i needed to switch to a new drug anyone, then sure. Why not? But not if what I have is working.
A consultation from my gastroenterologist, access to see my gastroenterologist on short notice if the new medication is causing me issues.
A dedicated staff ready to accommodate a patient in need day or night anyday of the week month or year.
A discussion with my GI before any changes
A discussion, at least, with Gastroenterologist as to whether it is in my best interests to do so.
A form from my GI; proof of other treatments.
A meeting with my GI and nurse. Also others who have switched to see how their bodies reacted to it.
A meeting with my sons treatment team at sick kids as i would more want him to switch to a biosimilar as he has been a very complex Crohn's pt since being diagnosed last year
A meeting with the gastro with an explanation of what to expect and what the risks are.
A normal meeting between me and my gastroenterologist
A very thorough follow-up with my GI team to be absolutely CERTAIN that it will not cause a flare-up.
Absolutely! Transitioning to new medication would be very frightening and unsettling and uncertain.
Access to clinics, proof that I am not going to suffer from this change
Access to Mental health counselor, meeting with nutritionist and GI.
Added appointments with GI, increased monitoring (labs or imaging, etc) for initial phase of new treatment.
Additional support and time from gastroenterologist, treatment counselling
Additional time and support, even changing to a very similar generic could have changes.
Advise and agreement from my GI
All
All if the mentioned items
All of the above
All of the above
All of the above
all of the above
All of the above
All of the above!
All of the above.

All the above
any and all I can get.
Any switch from an effective drug to another (unknown effectiveness) requires a suite of patient supports. These supports must include dietician support, additional GI specialist counselling, more frequent clinical follow up (bloodwork, endoscopy, colonoscopy). In addition, supports for mental health are required. Changes to a medication regime can have profound impacts to a patient (and their support network)'s mental health as it relates to confidence in their state of health.
Anything and everything that would be available
Appointment with gasteroengerologist, information sessions.
Appointment with gastroenterologist would be needed.
Appointment with gastroenterologist, meeting with gi nurse, follow up appointments and blood work and tests to confirm effectiveness
Appointment with GI to discuss action plan for treatment and backup options, assistance with insurance coverage, discussion with new drug company/rep
Appointment with my gastrointestinal doctor and follow up tests to make sure drug that was forced to switch to works
Appointments with my GI doctor and/or GI nurse. Support from drug provider (as I currently receive) Counselling as fear of switching to something potentially not as effective could lead to anxiety
Approval from my GI that assures the switch in treatment from a biologic to biosimilar would be just as effective and not jeopardize my health and progress.
As mentioned above - special counseling from GI, meeting with GI nurse. Can patient go back to Remicade if alternate drugs do not work? You are potentially ruining someone's remission and eliminating a safe and proven therapy.
Avis de la gastro-pédiatre
Avis de mon gastroentérologue sans aucun doute.
Clarification on what this could mean concerning my health & closer help from GI
Clear information on the matter (from my gastroenterologist); summary of research proving that it is safe to do so; a "plan B" to revert to medication that works for me in case of complications
Clinic visits and follow up with GI and Rheumatology team; additional follow up appts to track response; potentially additional procedures/tests to evaluate any changes (scopes, etc)
Close follow upd
Close Gastroenterologist follow-ups to make sure disease stays in remission
Close supervision by a health professional.
Conclusive research and consultation with GI
Conseils pharmaceutiques
Constant monitoring/testing. Nova Scotia MSI does not cover fecal calprotectin tests. I had them done through Remicade/janssen. After coming off a biologic I wasn't able to have the tests covered

Consult with gastroenterologist, pharmacist consult
Consult with GI doctor or nurse proving the same efficacy of the biosimilars with the brand with significant statistics
Consultation abec gastroentérologue, rencontre avec infirmière spécialisée en MII.
Consultation avec Gastroenterologist
Consultation avec gastroenterologue
Consultation avec gastroentérologue
Consultation avec gastroentérologue de l'hôpital pour enfant de l'est de l'Ontario
Consultation avec gastroenterologue, j'exigerais d'être informé des risques et effets secondaires.
Consultation avec mon gastroentéroloque
Consultation avec un gastro
Consultation avec un gastroenterologue
Consultation gastro   Infirmière   Prise de sang   Suivi etc
Consultation gastroenterologists, support from family, possibly more regular blood tests
Consultation on any differences between the drug by a medical specialist
Consultation with a GI Specialist
Consultation with GI care provider and commitment to followup more frequently with no iririmg of inflammation markers (I.e. blood work, GI ultrasounds, etc.)./ With the promise to return to previous treatment with continued health care coverage (Remicade) if biosimilar is ineffective.
Consultation with my care team to determine next steps
Consultation with my Gastroenterologist. Have not had much luck finding a medication that has been effective in achieving/maintaining a remission.
Consultation with my GI specialist, surgeon and obstetrician
Consulter gastro-entérologue pour savoir les conséquences de ce changement
Consultez un gastro-entérologue
Could require appointment with GI, more labs as well as continued labs, access to GI nurses. Follow up with G.P. And other specialists. May require new scopes.
Councilling from gastroenterologist and general practitioner, travel grants and hotel accommodations.
Councilling from gi and immunologist
Counseling from gastroenterologist
Counseling from gastroenterologist
Counseling from Gastroenterologist, proof of same efficacy of biosimilar.
Counseling from GI, probably more colonoscopies to ensure my condition doesn't reflare, additional medications to maintain may quality of life (opiates, marijuana, steroids), more sick days from my employer, someone to explain all of this to my employer, help at home to care for my kids and home because I anticipate the return of my fatigue and joint pain
Counseling from my gastroenterologist followed closely and monitored by my GI nurse

Counseling from nurse or dr on side effects and other changes that may occur.
Counseling with gastroenterologist, reassurance that this drug is going to do the same. Currently Remicade is working and do not want to change just because of cost
Counseling, psychologist, caregiver, chauffeur, plus any other help if my disease becomes active again.
Counselling
Counselling for sure
Counselling from gastroenterologist
counselling from gastroenterologist
Counselling from gastroenterologist
Counselling from gastroenterologist
Counselling from gastroenterologist and meet with GI nurse.
Counselling from gastroenterologist; Meeting with GI nurse; Meeting with immunologist; Counselling from psychiatrist; other
Counselling from GI
Counselling from GI
Counselling from GI and support if my reactions change.
Counselling from my doctor
Counselling from my gastroenterologist
Counselling from the specialist
Counselling Services GI appointments - more frequently
Counselling with both my GI & rheumatologist.
Counselling with GI doc or GI nurse with data proving efficacy of biosimilar formulations
Counselling, nurse, and social assistance as I would be unable to work if I am experiencing symptoms.
Counsellor to deal with the anxiety it may cause to switch.
Currently, I am in remission and therefore I would be concerned about my disease de-stabilizing and would require discussions with my G.I. and ongoing monitoring. I have already lost response to other biologics, have had several surgeries and have been very ill with crohn's...so to force a change in medication from something that is currently working would cause me a great deal of stress and anxiety. I would also need financial support put into place
D'infOrmation, de consulter mon gastro-entérologue, de comprendre les impacts sur ma santé, d'un suivi plus serré, soutien psychologique
Definitely any sort of support from doctors and nurses to make sure the transmission is smooth
Definitely confirmation from GI doctor this will not have a negative effect. And if thr new medication doesn't work how would i be helped?
Definitely consultation with medical team on what this means
Definitely meeting with my GI doctor/nurse
Definitely support from GI physician and nursing staff

Definitely would need proper paperwork from GI and supporting reasons why to stay on any specific meds
Depends on how it affects me
Des fonds pour qu'on puisse rendre visite à notre specialiste. Le médicament est couvert pour l'instant, mais les frais de déplacement sont exorbitant
Different Infusion clinic - need to know the new clinic can support the mandated switch. Need to know the new patient support program can handle all the new patients. Are we sure that there won't be a shortage of the new medication? Will my doctor help with this? He's not the one who wants this
Discussion with (advocacy by) my GI and surgeon as I have chronic fistula and am terrified that I will lose quality of life again if biosimilar not as effective. Took 7 yrs to find the right med/dose (Humira 80mg/weekly) and co-med (Imuran) that gave me back my quality of life; this after trying several others. It's working I want to keep it working. I am terrified of losing QOL if biosimilar doesn't work. I'm also terrified that by switching I'll develop antibodies to Humira and not be able to switch back...
Discussion with Gastro MD about implications (having been on Remicade for 13 years)
Discussion with gastroenterologist
Discussion with my G.I.
Discussion with my own GI
Doc consult
Doctor input
Dr. Input
D'un soutien aussi exceptionnel que celui dont je bénéficie maintenant et qui a contribué à ma rémission (Le meilleur Gastroentéroloque: Dr. Raymond Bourdages et médicament Humira)
services spéciaux de consultation avec un(e) gastroentérologue; rencontre avec une infirmière ou un infirmier spécialisé en gastroentérologie; autre).
Être informée sur les effets secondaires à 100%. Diététicienne.
Every bit going
Everything listed above
Evidence to support outcome is close/the same as to current biologic therapy, what are the risks associated with switching therapies, meeting with GI
Explanation from doctor
Extensive consultation with my specialist whom administers my current biologic.
Follow-up with GI
Free parking to the hospital, more appointments to the GI for status checks, a way to switch back to the treatment that works for one.
Frequent hospital visits or other additional attention from a doctor, surgeon, nurse, etc.
Full consultation with GI, however in NS they've committed to no biosimilars, if this has changed I haven't heard I did push the gov't for no changes.

Full workup to evaluate
Gasterentetologust
Gastric support,
Gastro
Gastro
Gastro
Gastro
Gastro
gastro counselling
gastro et inf
Gastro et infirmière
Gastro et rhumato
Gastro meeting.
Gastro or GI nurse appointment
Gastro physician to approve of switch
Gastro. Psy. Chirurgien a cause des fistules. Infirmière spécialisé et un suivi rapprocher
Gastroanterologue
Gastroanterolue
Gastroenterologie
Gastroentérologie
Gastroentérologie
Gastro-entérologie
Gastro-entérologie
Gastroenterologist
Gastroenterologist
Gastroenterologist
Gastroenterologist
Gastroenterologist
Gastroenterologist
Gastroenterologist
Gastroenterologist and Psycholgist counselling. It's been very hard to have some control over UC, switching meds and facing a setback is unthinkable to me. Would be a disaster.
Gastroenterologist, GI nurse and Bioadvance care coordinator
Gastroenterologist, ibd nurse
Gastroenterologist, meeting with doctor, meeting with Home Care, meeting with supplier as we are rural, meeting with family dr, etc
Gastroenterologists
Gastroenterologists and hospital

Gastroenterologue
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Gastroentérologue
Gastro-entérologue
Gastro-entérologue
Gastroentérologue
Gastroentérologue et internist et MD de Famille
Gastroentérologue et spécialiste médecines internes
Gastroenterology
Gastrointestinal doctors
Gastrologue
GE
GI
GI
GI Dr mtg has had reaction to generic drugs in past. Need special permission to stay on current drugs
Gi Couselling and the ability to switch back if testing (blood) says it is not as effective
GI dr
GI meeting/ consultation
GI nurse
GI nurse, pharmacist, gastroenterologist
GI nurse, regular appointments with gastro specialist during changeover, and possibly time away from work to alleviate stress to help my body during the change.
GI should have to approve it.
GI specialist
GI specialist

GI, GI nurse, pharma coordinator
Gi. counselling
Guidance from gastroenterologist and his support staff.
Guidance from GI
Have to meet with gastroenterologist
I am still new to remicade, so not totally sure how a switch would go. Definitely mean more appointments and work ups with the GI and NP.
I assume that I would need to see my GI doctor and have additional ultrasounds or colonoscopies to see if the treatment is working.
I don't know. Likely extra appointments with my gastroenterologist and GI nurse, assistance navigating my insurance program at work, etc.
I honestly don't know what I would need. My first instinct would be to speak with my Internist to seek his advice on how to proceed.
I think the best approach would be an appointment with my GI to address my needs and concerns before the switch. Following the switch, I'd need support with a GI nurse to make sure everything stays smooth for me. When I'm in remission, I would genuinely pay the difference in costs of medication to stay on the formulation that has kept me in remission. Forgive the crudeness, but pain-free and pooping is the goal here, not cost-cutting.
I want to keep my current community IBD nurse because she treats through all biologics and knows me.
I would absolutely have to see my Gastroenterologist. Medication is so crucial in controlling my illness, and being bumped off of it to another drug would not be an easy experience. My flares land me in the hospital and I would not want to go through all of that because a provider is subjecting me to an experiment in cost-saving measures. Suffering a flare is hell, it puts my life (and that of my family's) on pause.
I would be concerned about the other drug being as effective- I would want to discuss it with my doctor
I would defer to my doctor
I would definately want special counselling from my gastroenterologist to be absolutely sure that switching to a biosimilar will be safe and as effective in my individual case
I would first need very high confidence that the switch would not cause a flare up or treat my Crohns any less efficiently than remicade currently does. I would like to have a convo to discuss this with my Gastro Dr before the switch was made.
I would like answers from gastrointestinal Dr.
I would like to know my gastroenterologists opinion.
I would need reinsurance from my gastro that this will still be effect and I will not fail the medication
I would need a consultation with my gastroenterologist.
I would need a meeting to discuss with my GI doctor and Nurse to be sure they also agree.
I would need GI counselling as dealing witg the changes would be too much to deal with on my own without causing a flare up
I would need more information from my GI and a back up plan

I would need more informations from m'y doctor about the switch to another treatment, why and the side effets.
I would need to be reassured by my entire care team that a biosimiliar would maintain the quality of life I've enjoyed on Humira for the past five years.
I would need to confirm with the gastroenterologist that it would be safe for my daughter to switch. I would like to know what the statistics are when switching to a biosimilar drug and what the potential side effects are
I would need to consult with my GI
I would need to discuss this with my GI in Ottawa which is over an hour away.
I would need to go to my gastroenterologist
I would need to have more medical work done to look at how my inflammation is, potentially meet with another GI speciaclist and change my current regime which seems to be working
I would need to meet with GI specialist, proof it would work and the same amazing support program the juniors provides. They make my life so easy and check on me often.
I would need to meet with my GAstroenterologist. I would more then likely need monthly follow up blood work and various tests to insure the new medication is working properly example colonoscopy and dye enhanced ultra sound. I would love to have a GI nurse I could talk to about issues as I do not have one at present
I would require counselling from my GI doc or NP, and reassurance that if I were to once again have symptoms, that I would be able to switch back to the medicine that kept me in remission.
I would require the same check-ins/appointments with my GI specialist and my GI nurse to ensure my disease is under control.
I would require to meet with my GI nurse to discuss the changes, work with my GI to ensure the new treatment is actually going to put me into/keep me into remission.
I would verify first with my specialist.
I would want to meet with my Gastroenterologist to discuss what the effects might be
I would want to speak to my specialist before i make such an drastic change so i can be more informed about the new medicine that they decide to put me on
I would want to talk to my Nurse Practitioner to have them validate that the medications are effectively the same
I'm not sure. Gastroenterologist I guess.
I'm terrified of switching to a bio similar and flaring. I would definitely need psychological help for stress and anxiety due to worry about flaring. During a flare I would need many appointments with my GI in person and GI Nurse over the phone. My quality of life is barely acceptable and I'm borderline suicidal as it is.
If it is enforced I believe I will need more frequent trips to my GI to make sure it is working as well as my current medication. I also think support if I am to be hospitalized due to flare ups from the biosimilars would be fantastic.
I'm not sure. I guess meeting with gastroenterologist
Infirmier spécialisé

Infirmière
Infirmière en gastrto
Infirmière et gastro-entérologue
Infirmière spécialisé
Infirmière, gastroenterologue
Information about what will happen if the biosimilar is not as effective. Counselling and information from a GI nurse who knows me well or my gastroenterologist.
Interniste
It would probably mean more appointments with my daughters GI team which is a 5hr drive away from us. We were just moved to an every 6months appointment and I would assume that with a medication change it would require more monitoring which may mean more appointments.
It's hard to say as this is the first I'm hearing about this but I would want to meet with my GI to hear about what the impact of switching could be. It took almost 2 years for a diagnosis and to get into remission so it's scary to think about switching when I just found something that works and my quality of life has drastically improved.
J'aurais besoin de voir mon gastroentérologue pour me guider dans mon autre traitement.
Je devrai revoir ma gastroentérologue car j'ai vraiment très peur de changer ma médication. Avec le Remicade depuis 10 ans et tout va merveilleusement bien depuis 10 ans. Aucun symptôme depuis tout ce temps. Ma qualité de vie depuis Remicade est excellente et totalement remarquable. Un médicament miraculeux pour moi et pout tant d'autres.
Je voudrais bien en discuter avec mon spécialiste gastro
Je voudrais que ce soit approuvé par ma gastro-entérologue
Just regular check-ups with my gastroenterologist.
Le service de perfusion et de soutien étant déjà inclus dans le prix, est ce que le générique doit être déboursé séparément et fourni par quelles cliniques.
Letter from GI doctors with reasons why my family member should not have to switch.
Medical specialist suppory
Medical support for sure. Not having to wait 6 months to see my GI doctor.
Meeting with gastroenterologist and subsequent monitoring to ensure that new treatment is proving as effective as previous.
Meet gastro and GI nurse
Meet GI But have been on waitlist for 2 years to see one
Meet w/GI, meet w/pharmacy that supplies, meet w/payer that pays (I receive government assistance for payment of Entyvio)
Meet with Dr to discuss it
Meet with Gastroentrologist and GI nurse
Meet with GI
meet with GI Nurse
Meet with my gastroenterologist ASAP.

Meet with my GI specialist to hear their opinion
Meeting (s) with à qualified/expériences nurse with inflammatory bordel desease should be sufficient
Meeting / discussion with GI
Meeting to discuss the efficacy of the new drug, why after 13 years of healthy living and growth is there a change needed, is it wise to make this change
Meeting with a gastroenterologist and gi nurse. It should be my decision I dont think it should be forced. My doctor knows the right treatment for my illness.
Meeting with doctor, GI Nurse, BiAdvance Coordinator, and someone to explain why we're being forced off our meds that are working
Meeting with doctors to approve it
Meeting with dr
Meeting with Dr. Or nurse practitioner and evidence that it is just as safe for my 9 and 2 year old with Crohn's.
Meeting with g.i. specialist
Meeting with gastro
Meeting with Gastro, stock up on toilet paper, iron supplements, hire more staff and train so they could cover my future shifts at work,prepare an emergency kit with extra underware and wipes.
Meeting with gastroenterologist
Meeting with gastroenterologist and GI nurse
Meeting with gastroenterologist and research evidence
Meeting with Gastroenterologist and support during transition
Meeting with gastroenterologist for information and meeting with payers
Meeting with gastroenterologist.
Meeting with GI
Meeting with GI
Meeting with GI
Meeting with GI
Meeting with GI
Meeting with GI
Meeting with GI
Meeting with GI
Meeting with GI
Meeting with GI
Meeting with GI
Meeting with GI - I have concerns about efficacy, and if the biosimilar is ineffective will I be able to switch back? I've heard that people who go off remicade are more likely to have infusion reactions.

Meeting with GI Work place accommodations	
Meeting with GI and GI nurse. Call with care coordinator,	
meeting with GI doc to find out the effects of the new drug	
Meeting with GI doctor	
Meeting with gi doctor	
Meeting with GI doctor	
Meeting with GI doctor	
Meeting with GI doctor in another city, more closely monitored care by GI nurse and doctor of side effects	
meeting with Gi Doctor or nurse	
Meeting with GI doctor. Understanding why I would be forced to be moved off a medication that is working	
Meeting with GI Nurse about what differences are and what to expect and problems that could occur being forced to switch	
Meeting with gi nurse and counselling from gi	
Meeting with GI nurse or doctor to understand any differences in treatment, to be educated that medication will work adequately, etc	
Meeting with GI nurse or gastroentrologist on semi regular basis	
Meeting with GI nurse regularly / special counselling from gastroenterologist	
Meeting with GI nurse to discuss difference in treatment.	
Meeting with GI nurse, and ongoing appointments with gastroenterologist to make sure the switch doesn't make me sicker. It takes us so long to find something that works, I just don't want to take that risk	
Meeting with GI nurse, other things	
Meeting with GI nurse; someone to talk to about the risks/benefits	
Meeting with GI pre switch and then after the "weening" process to the biosimilar	
Meeting with GI specialist, extra testing to ensure new meds actually work (monitoring more closely)	
Meeting with GI to discuss how the drugs would interact with me	
Meeting with him and extra support in the event of not responding to new treatment	
Meeting with my Chrons doctor plus my nurse. Have to inform my management.	
Meeting with my doctor to inform me and tell me what to do.	
Meeting with my gastroenterologist	
Meeting with my gastroenterologist to discuss	
Meeting with my Gastroenterologist to explain the effects of the switch and consequences on my health and quality of life. I'm really scared of this switch. I just achieved remission after many years of flares and sickness. That could potentially be disastrous in my case	
Meeting with my gastroenterologist. Written materials showing the scientific basis for switching. Documentation outlining my options if the biosimilar is not effective.	
Meeting with my GI	

Meeting with my GI
Meeting with my GI and GI nurse and more follow ups to make sure I don't end up in a flare
Meeting with nurse
Meetings with nurses and or other health professionals to address the potential impact this may have on my well-being and health.
Meilleur suivi de mon gastroenterologiste. Calprotectine et prise de sang mensuelles.
Micro monitoring by professionals
Monitoring by GI nurse
Monitoring by medical professionals
Monitoring, blood tests and emergency treatment if the shift led to a flare up
More access to gastroenterologist, ongoing nursing support, access to testing to ensure inflammation not returning
More appointments and probably more scopes.
More appointments with GI to address concerns and follow symptoms.
More consistent meetings with gastroenterologist to make sure condition remains stable/in remission
More doctors visits, more nurse visits, therapy in regards to disease management and mental health, financing to cover potential time for missed work
More frequent dr visits to ensure remission is maintained and that potential flare ups are diagnosed quickly.
More GI visits
More information from my gastroenterologist
more information from my GI about the implications, and how this affects other patients.
More ready and local access to GI support. We currently travel almost 2hrs one way to see his specialist. There would need to be intensive monitoring of all symptoms and medication levels at a much higher level then currently required
More regular appointments with gi doctor, more frequent blood work, more frequent scans and scopes.
More scopes to test results. Special changes if biosimilar does not work. Off work due to issues. Quality of life changes.
More time spent with GI specialist, more maintenance appointments. Before Remicade, I had 2-3 flare ups a year with two needing Prednisone. After four years on Remicade, zero flare ups.
More visits with my GI doctor Probably more rounds of steroids.
My 12 year old son was diagnosed with Crohn's in May 2019 and was started on Renflexis, I don't know enough about the difference between this and the biologic drugs to have an educated opinion. I'd need a consultation with a Ped GI Dr to be educated.
My current treatment of Remicade works great. I would not want to risk having a flare by changing treatments unless absolutely necessary. I would need to see my gastroenterologist if i was to change treatments.
My daughter would need special counselling with gastroenterologist and pharmasist.

My gastroenterologist
My gastroenterologist would counsel me before any changes to my treatment would happen regardless.
Need to meet with my Gastroenterologist to ensure that this would not change my outcome.
No counselling available I tried to have answer nobody is helpin
No, remicade is the only drug that has worked for my disease and kept me in remission. Being forced to switch could mean going back to a flare and suffering. We should not be forced to change medications tbat are currently working for us. If they switched i would need better access to my GI doctor and supports from the province if i flared and was unable to work
No. Consults with drs, nurses, other people who have switched.
Not sure, probably appointments with gastroenterologist, GI nurse, etc.
Not unless necessary. I would need treatment plan created by my GI and to have access to a GI nurse.
Nous avons déjà un suivi aux 3 mois avec la gastroentérologue
Nurse
Nurse, gastroentérologies
Oulala.... je serais extrêment stressée. Ça pris tellement de temps à trouver le bon dosage. Donc je voudrait un suport de gastro., infirmière et peut-être avoir le soutien d'un psycologue.
Probablement une rencontre avec mon gastroentérologue ou ma coordonnatrice.
Probably counselling with the gastroenterologist along with the GI nurse
Psychological support. A guarantee that it would work exactly the same.
Reassurance from my gastro that new drug is as effective as Humira
Reassurance that I would stay in remission. Not sure who would be able to provide that to me.
Reassurance that my medication was going to continue work
Recontre avec mon médecin traitant
Regular check ups with GI to monitor disease, information on drug plan coverage and possible limitations,
Rencontre Avec gastro enterologue
Rencontre avec gastro entherologue ou imfitmiere
Rencontre avec gastroentérologue et infirmière.
rencontre avec infirmière
Rencontre avec infirmières, documentation claire sur le pourquoi
Rencontre avec le gastroentérologue
Rencontre avec mon gastroenterologue
Rencontre avec mon gastroenterologue pour en discuter, discuter des impacts associés à ce changement sur l'evolution de ma maladie

Rencontre avec spécialiste de la santé mais aussi m'aider au niveau assurance. C'est très compliqué et de l'aide à ce niveau pour un changement de médicament est primordial. Aussi les impacts que le changement pourrait avoir sur ma santé
Rencontre avec un gastroentérologue
Rencontre avec un gastroentérologue ou une infirmière spécialisée en MII pour en discuter.
Rencontre avec un médecin
rencontre avec une infirmière spécialisée en gastroentérologie ou gastroentérologue
Rencontre avec une infirmière spécisoaliser ou gastrointerologue
Rencontre avec une infirmière.
Rencontre équipe médicale
Rencontre mon médecin en gastro-entérologie
Rencontrer ma gastro enterologue voir si ce produit est aussi efficace que lui que jia presentement
Rencontrer un gastro-entérologue
Rendez-vous avec mon gastroentérologue.
Review with gastroenterologist and GI nurse. Humira is the only medication that has worked for me so far. Training on application (neele or infusion) and information to review side effects of new drug. Possible time off work to adjust to new side effects, etc.
Routine bloodwork to monitor for a flare
Routine meetings with my GI and nurse team. Details on stats and side effects of new drug(s), legal reasons why I need to change medications.
Service consultation avec Gastro-entérologue
services spéciaux de consultation avec un(e) gastroentérologue de très près et un suivi très rigoureux pour des examens et prise de sang en cas inefficacité du au changement de médicaments, risque de non réponse à un médicament bio similaire et de rechute du Crohn. Il est risqué d'interrompe le traitement par un autre traitement car les effets escomptés après avoir cessé Remicade sont souvent nul lorsque ré administré.
Soutien de mon gastro-entérologue
Special appointment with GI Doctor. The potential stress may require consultation with psych./counsellor
Special appointments with gi doctor and nurse
Special attention from doctor to make sure that you don't come out of remission
Special councelling from a gadtroenteroligist
Special counseling from gastroenterologist, frequent follow ups to ensure treatment is working
Special counseling from gi doc
Special counseling from GI. Support/therapy to deal with the fear of switching off of a medication that works. Pharmaceutical support to answer questions about treatment and relationship with pregnancy and breastfeeding, immunizations, infections, etc.
Special counseling with gastroenterologist
Special counselling

Special counselling and meeting with gi nurse
Special counselling from a gastroenterologist
Special counselling from a gastroenterologist and my family doctor.
Special counselling from doctors and nurses specializing in these treatments and the affect in changing from current biologic.
Special counselling from gastro
Special counselling from gastroenterologist
Special counselling from gastroenterologist and more support from humira program with help
Special counselling from gastroenterologist, psychological counselling for anxiety caused by fear of switching
special counselling from gastroentrologist; conversation regarding coverage with the current health care plan.
Special counselling from GI and/or meeting with a GI nurse would be necessary to ensure that medicine is working appropriately and to discuss symptoms that arise with treatment using biosimilars.
Special counselling from GI, visit to family doctor to confirm compatibility with other medications, a new infusion centre and all the administration that comes with that, potentially adjustment period to new med causing side effects and missed work
Special counselling from my gastroenterologist or her nurse, any necessary support required for me to access and receive treatment. Currently drug companies have people that can coordinate with health insurance providers and schedule treatments and drug access for patients. I would require the same if the treatment is via IV for instance or needs to be ordered through a special pharmacy. I'd also like to ensure that certain tests such as drug levels, and fecal calprotectin are still covered.
Special counselling from my gastroenterologist.
Special counselling grom G.I, anxiety treatment as the potential side effects or not working well leaves me feeling vulnerable.
Special counselling with gastroenterologists, review with family doctors, consultations with current fertility specialists
Special counselling, information sessions
Special counselling, repetitive meetings with drs and nurses, potential financial assistance if not covered, potential financial support if I my current remission ends and my aggressive form of Crohns disease takes control of my body and demands endless emerg visits, hospitalizations, prescriptions, surgeries, etc., potential ongoing medical care from other sources...chiropractor, naturopath, massage therapy, dietician, psychologist...
Special services
Specialist appt.
Suivi auprès de mon gastroenteroloque.
Suivi avec gastro-entérologue
Suivi avec gastroenterologue et suivi infirmière
Suivi avec mon gastroentérologue une infirmière et ma rhumatologue

Suivi par infirmière spécialisée pour registre des effets secondaires ou changements efficacité du médicament
Suivi rapproché avec mon gastroentérologue.
suivi régulier avec un gastroentérologue qui pourra intervenir rapidement au niveau d'un changement de médication dès les premiers symptômes d'inflammation ainsi qu'un suivi avec une infirmière spécialisée
Suivi serre de la part de mon équipe de gastro-entérologie car je n'en veux pas risqué de récidive pour une question monétaire
Suivi très régulier avec gastroentérologueue, accès rapide à une infirmière spécialisée en gastro-entérologie afin de permettre un accès facile au gastro-entérologue si complications ou retour d'une crise.
Support from gastroenterologist
support from gastroenterologist
Support from gastroenterologist. It took forever to find a drug that helps. Would be like starting from scratch and probably compromising my health.
Support from my doctor.
Support team to assess my health, blood work to ensure treatment is effective, financial aid for any loss of work time
Talk to my GI doctor and nurse.
Tighter follow-up with grastroenterologist
To be closely monitored by my GI. Reassurance that if the bio-similar doesn't work as it should that I would be put back on my original biologic
Un psychologue car je suis certaine que je paniquerais et que j'aurais peur que ma maladie rempire
unsure what supports would be needed. I'd want to see clear and valid research before any switches are made. This could cause major upheaval to many lives if the new meds are not as effective!
Voir mon gastro
Voir un gastroenterologue
Who knows right? Its an unknown. Systems of auto immune patients are sensitive. For sure, a GI, an IBD nurse, counselling regarding differences in drug, and reaction.
Would need more information but certainly consolation with GI about impact of the switch etc.
Would need much more support and we live over a hour to the major city where the doctors and specialists are available.
Would need to know the ramifications of changing treatment from Gastroentrologist
Yes all the above
Yes meeting with gastroenterologist
Yes to all
infusion clinic: location, availability
injection support

Just ensure my husband can still access a place to get his medication
A Gastroenterologist should be the only person making decisions as to a patients medical care.
A switch should only be made if needed medically, as per the GI team.
Absolutely not
Absolutely not especially if the medication being taken is working.
Absolutely not! Remicade works for me. It put me in remission. I would be terrified to have to switch.
All of the above. This is a real concern. Cost effective doesn't mean it will work for the patient. I know my daughter will worry about this change if enforced, as will I.
Don't know. I would NOT want a forced switch for anyone.
Gastroenterologist should be the only person making and deciding on medication changes for any patient.
Given the disease, finding a medication that works is a damn miracle on its own. Having to switch from one to another can make many others not an option anymore. Screw the money, we dont want to die
Given the severity of my CD, it would be very unsafe/unwise to switch to a similar option which may be needed in the future (if current biologic were to cease working). I'm so severe, I'd need to relocate to Toronto to be monitored *very* closely by my medical team.
I do not want to switch. I don't feel the research supports it. I would want assurances from my GI that I am not at risk of a flare due to switching. I would want closer monitoring of my health and faster responses if I end up in a flare because of forced switching
I don't understand the question. I know I don't want to be on a drug that was 'chosen' for me for financial reasons. These diseases can be hell, and needed to be treated wth the best possible medications
I don't think it should be enforced. Counseling from gastroenterologist
I don't think you should be forced too. What happens if the biosimilar doesn't work? Now we're back at square one.
I refuse to switch
I see my GI atleast a couple times a year. The Doctor would be the only person that I would consult with about what medication is available and that would work best for me.
I think it should not be enforced by province or private payer. The dr. and patient should have the right to make that decision on what works best for them.
I think it would have to be decided on a patient by patient case. You cannot just switch a patient to a new med to save money as certain medications do not work for everyone.
I think the decision to switch to a cheaper treatment should only be made by the patient or caregiver, and only after the patient or caregiver has been given all information about new treatment and potential side effects and any risks involved.
I would need a LOT! My son has been on Remicade since he was 7 and is now 14. He is healthy and active and doing well because of his remicade. I am not willing to compromise on that at all.

I would only switch if my gastroenterologist said it would be okay.
I'm against the idea that such a switch would be enforced on The patient. It is the right of the patient to choose how she/he will be treated.
I'd be a huge mess. It would be mega scary. I have to drive half an hour for work each day and if I cant make it to work I can lose my job. I cant afford to risk other drugs not working and going into a flare up.
It is being enforced in BC and I am not pleased.
It should be a personal decision made between patient and doctor
It should be my choice with input from my dr! definitely not a decision made by companies
It should be the patient's choice. Before any type of switch you should have the opportunity to sit and speak to someone that can provide you with all the pro's and con's and all neccessary information that you should need to make an informed decision on whether this is the right move
it should not be enforced as each person is different , there should be counselling if needed from Gastroenterology as well as nurses and a community group of people with this illness. offer room for people to bring someone with them to help then through the procedure.
It should not be forced. It should be a choice motivated by results and success of the biosimilar. It should only be motivated by money (saving money) as a last resort
It should only be a switch if Doctor recommended.
It should only occur if the cheaper treatment is as effective as the original; and it should be approved by the PATIENT'S doctor as an acceptable substitute.
Je travaille dans le domaine pharmaceutique et vu mon expérience un produit générique n est pas nécessairement fabriqué dans les mêmes conditions
My current treatment is working since 10+ years,changing it would only make it worse
My Gi strongly believes that what I'm doing is working, so don't change a thing.
Never enforced. We know our bodies better than anybody..sometimes even better than our doctors. Even similar drugs don't work the same now for us
Never! I should only be switching my treatment because my current one stopped working.
No
No
No
No
No
No
no
no
No
NO
No

No
No
No
No
No
No
No
No
No
No
No
No a switch should not be enforced.
No absolutely not. It takes so long to find a medication that works for each individual person that switching is far too risky.
No it should be whatever medication is working for you, the cost should not be a factor or decided by a someone else
No it should not
No it should not as everyone's disease is different and different drugs work differently to everyone
No it should not be enforced
No it should not be enforced
No it should not be enforced since switching may cause more complications if the new treatment is not as beneficial as the current treatment.
No it should not be forced.
No it shouldn't be enforced. I've heard they don't work the same. That you switch off remicade to a biosimilar. Then if remicade was working but biosimilar doesn't. You may now have immunity and remicade not work anymore. I would never ever want to switch when something is working
No switch should be made without prior approval from gastroenterologist
No this should not be allowed. Why change what's working
No way to know. My daughter has been in remission since starting Remicade. We would be devastated to have symptoms come back. She is happy and healthy now.
No way!
No!
No!
No!!!!   Only my doctor knows what I should take. Not the government.
No, a switch is too risky. I would support a person being started on a bioidentical but no to a switch.

No, if your current medication is currently working you are risking a chance of becoming very sick and suffer for more immense pain because a cheaper medication didn't work. Once you stop one biologic, if you ever try it again it's more likely that you can have an adverse serious reaction to the drug that once changed your life to almost living like a normal person. If Remicade is helping my Crohn's and allowing me to work and be the mother of my child and to be present to care for my family when before Remicade I could barely lift a finger, why should I be forced to change, I have a right to refuse medications and I refuse to take any biosimilars while my Remicade is working! This is not right to enforce this upon those who suffer immensely everyday even when feeling well, those trying to enforce this change upon us do not know how it is to go through the lifelong process of dealing with Crohn's or colitis until they have been through the same.
No, it should be up to the doctor and patient. They know best.
No, it should be up to the individual receiving treatment or parent to make that choice.
No, this needs to be a personal choice made with doctors, and possibly family members that would be affected (caregivers).
No, would be lime starting over, takes years sometimes to go into remission
no, you should switch when the medication no longer keeps symptoms under control
No.
No. Those treatments may not work and what works for some may not work for others. It should not be dictated based on cost. It should be what best suits the patient without compromising their health
No. Each patients doctor should determine best treatment plan.
No. I believe a patient should not be forced to take a sublime trip drug. Especially when the drug you're currently on is working. Why take a risk and start something else just to save some money.
No. I need to be able to choose what helps me.
No. I would be scared to change. We are told that the Remicade might stop working especially if we were to stop for some reason you can't go back. That is my understanding. Unless there was 100% proof I would be afraid to change.
No. It should be determined after consultation with GI and patient. Should be what is most effective and beneficial for patient.
No... no one other than you or your doctor should be able to make these changes
No; the current drug is working and keeping my son in remission - there is not enough evidence to support that a switch would not be detrimental to his current health status
Non
None. It should not consider cost at all, only evidence as which is the safest and best medical option.
Not at all. If it is keeping me in remission why mess with that
Not worth the risk to switch because I'm currently in remmison and been threw hell with this disease
Nothing

Only if it's by your gastroenterologist and if they feel it's better for you. These drugs really take a toll on your body and needing to restart all over is terrifying
Pas ma gastroentérologue car elle a déjà reçu un non du gouvernement et ne peut rien faire pour l'instant... Alors je ne sais pas peut être une personne au gouvernement qui pourrait entendre ce que le médecin à a dire
Permission should be asked from the patient. Counselling regarding any possible changes/symptoms. If the patient has undergone a flare or recently has, a change should not be forced.
Point blank if a treatment is working then being forced to switch could mean flares and no amount of “extra” support will be helpful or effective
Proof that the change would not make things go backwards. My family member has suffered many straight years with a flare, has failed a few biologics already and only after going through a severly rough (includes almost dying numerous times), patch is finally finding some relief with another biologic. I havrle read on numerous studies/research pages etc that if you find something that works, DON'T change it!
Refuser et voir un gastro d’une autre province.. Aller me faire soigner ailleurs avec le meme traitement.
Remicade finally has me stable and in remission. I have not missed work, I can participate fully in my work and family life, I have not been hospitalized since being on Remicade. To imagine going back to frequent doctor visits, hospitalization and being sick is horrible.
Remicade me maintient en rémission depuis maintenant 9 ans et demi! Je ne vous cacherai pas que j'ai des appréhensions. S'il donne les résultats, mais est significativement moins cher, j'essaierais
Should be up to the patient
Si c'était le cas j'aimerais avoir un aussi bon service présentement
such decisions should not be made by politicians on financial grounds. Alternatives could be tested over along period of time to ensure they are (at least) as effective but not forced on patients. This change should be only made on firm medical grounds when both specialist doctors, nurses an patients agree that the potential benefits out weigh the risk of changing medication.
The current medication is working, Therefore no one should be forced to switch. counselling is unnecessary and useless. Our gastroenterologist would recommend staying the course.
The patients doctor should be the only one to recommend a medication switch if the patients symptoms have drastically changed & with of course the patients consent. I feel sitting with my GI doctor & talking about new medications is best.
There should be no enforcing of a switch to alternative biologics unless DEFINITIVE clinical studies have proven there is ZERO possibility of reduced effectiveness. And ONLY then. It should be at the discretion of the patient's doctor or specialist as to whether the switch can be done safely or not. This should never be restricted by an insurance company or provincial government.

This is the main reason i have declined switching to biological drugs in the first place. I dont feel comfortable having my faite in the hands of people who have no clue what living with these deseases feel like. I dont think that a switch for current patients should even be an option unless they request it themselves...the process by which to get accepted to these programs is so lengthy that failure on a new drug could lead to someones death. Maybe the people that are making these decisions are the ones who need support councilling
This is unacceptable
Treatment should never be enforced especially when this involves switxhhing to a less costly alternative. Patients wellbeing should always be at the root of Gastroenterologist decision making in terms of best treatments available for their patients suffering from IBD.
We'd need everything. We'd have to start ALL over again. Her current protocol is WORKING. She's living the life she deserves. She's healthy. She's pain-free. To make changes to jeopardize this after all she's been through is inhumane and, quite frankly, a money grab.
When a medication is working for a patient and the dr supports remaining on that medication I do not feel it should be up to the government or insurance company to force that choice into a patient.
You should Not be pressured to have care from the unknown . This is not a dictatorship country.
As a patient that has been forced to change medications because they have stopped working, I am nervous to stop a good thing (Imuran,Remicade, Humira, Entyvio). I would be happy to try a biosimilar when it is time to try something new!
I already have had “counselling” from my GI and neither one of us are happy. Switching a stable patient after 10 years is a risk that only someone that does not have this disease can be comfortable with. I support new patients based on the cost, but us stable patients have been offered finical compensation from Remicade, there for benign NO reason to switch us and risk our already achieved stability. I need support to continue with Remicade at the competitive financial compensation being offered.
I think it is fine to start new patients on biosimilar drugs but is should not be ethical to do it if the current treatment is working for the patient
It should be approved under treatment strategy developed by GI. Maybe a tier approach based on results, using a biological similar first and biological second if symptoms don’t improve
Maybe for new patients. Not for people that are already on a drug that has put them into remission.
I won’t be switching, my Stelara is already approve for a year and renew are always approved
Started on Inflectra 2017 after unsuccessful try with Azothioprene. Would only need counsel if symptoms returned and needed to review options other than Inflectra.
?
Any or all of the above
Don’t know
Don’t know
dont know

Don't know yet.
I don’t current use biologic meds. I have no idea what I would need.
I don't even have a GI specialist in the province yet! I just moved to NB from NL. Soooo I have no idea.
I have no idea. If it ends up working, nothing more than I already have.
I'm not sure. I failed Remicade and have been stable on Entyvio for close to 3 years. It terrifies me to think about switching!
I'm not sure. My son has successfully been treated with biologics for 9 years and it would pain us greatly if he were forced to switched to something that is not going to guarantee his continued health.
I'm not sure?
I'm sure that help will be needed to answer questions.
Je ne comprends pas là question,désolé
Je ne sais pas
Je ne sais pas
Je ne sais pas
Je ne sais pas ben suis au début de traitement
Je sais pas ...
N/A
Newly diagnosed
No idea
No_ sure
Not sure
Not sure
Not sure
Not sure
Not sure
Not sure
Not sure
Not sure
Not sure
Not sure
Not sure how to answer this question
Not sure yet
Not sure.
Not sure...
sais pas

This is all dependent on how my body reacts to a different drug. I have been in remission for 8 years due to remicade so this news is very concerning for me
Unknown
Unknown
Unsure
Unsure
Unsure
Unsure on how to answer this correctly.
Unsure. What I have now works and it took a long time to get here. Don't really want to mess with it
We are newly diagnosed, so I am not sure at this time
A guarantee that this new drug would be just as effective. Remicade helped keep me alive for over ten years. It helped me make it through two pregnancies. It helped me recover and stay well enough to care for my two sons. As a patient, you never want to hear that price is the determining factor in your treatment.
Advanced heads up about what is happening when. The first I heard about anything was a Globe and mail article - no letter from GP no letter from GI no phone call. I'm fine with the switch but would like someone to walk me through when/how that goes down. Also I'm guessing no more Remicade coordinator? So maybe nursing support to get up to speed on managing med ordering/ impact on cost/subsidies/ insurance
All of the above
All of the above examples listed. List of pros/cons to change, possible side effects or issues, counselling support, etc.
All these drugs take time to enter your system for long periods of time before they become effective, how is going to affect our health during switch overs. I would want to see research data on the drugs before taking them.
An enforced switch to biosimilar drugs has been mandated with minimal information. During my last infusion I was told that the switch would happen within the next few months. I fear my Crohns will flare up and my current state of remission will change. I am angry and frustrated. Since taking Remicade for over 10 years with great success I worry about what minght happen to me once the switch to a biosimilar drug happens.
As long as it works well - nothing but the usual printout with drug info from my pharmacist.
Assurance that the new treatment would work at least as well as the original. Some generics work as well as brand names. Since biologics and biosimilars are newer, it might be more difficult to establish similar efficacy.
Avoir accès à des études qui prouvent qu'il s'agit de la même efficacité
Counselling and information
Data, confirming no substantial changes to outcome of the change to biosimiliar
De beaucoup d'explication car un traitement qui fonctionne coûte sûrement moi chère .
De tout les intervenants. Un service de premiere ligne pour avoir besoin des ressources nécessaires en cas de non reponse au nouveau traitements.

Des matériaux expliquant les possibles effets secondaires lié au nouveau médicament et au risque de changer d'un a l'autre
Education on the safety and efficacy of the biosimilar
Explicit information on how the biosimilar differs from the biologic, access to studies featuring comparative results, possibly meeting with a GI nurse. I would need enough information to understand the actual impact of the switch on me as a patient, not just fluff that suggests "it'll be fine".
Full disclosure of information of the drugs being switched to. Also full disclosure of all the risks, pros and cons, costs, who will cover the cost of the infusions and or injections. How often they will be required. Information fully disclosed as to the outcome of the Canadian Trials of these drugs. What reactions, risks etc. I have heard that these bio similar drugs have caused many health issues and even deaths. Very scary.
Get 100% reassurance that my daughter's body won't reject the biosimilar.
Guarantee that this change would not cause a flareup or worse.
I don't know. Do these less expensive drugs work as well? Is there a chance that switching could effect my remission?
I would like to see sufficient evidence that the switch is seamless and safe.
I would need education on the change why it's happening and does the drug work as good as remicade?
I would need to have actual proof that the drug would maintain remission and know that there is recourse and an EASY and smooth way to change back if remission was not maintained. I would need regular monitoring and testing to check for levels of medication and testing for continued remission. I would need to be informed of different and similar side effects and risks associated with a new treatment and reassured that there is no greater risk to my health with the change.
I would want evidence that the other treatment is as or more effective than my current treatment.
I would want to see evidence or a discussion with my care team about efficacy of biosimilars. And/or reassurance I could return to my original medication. It is precarious to do so if the results are not exactly the same.
Information about new drug
Information on the medication, what are the new side effects? Potential of it not working the same? Option to swap back?
information package about the changes and possible effects
Information session on potential health implications should it not be as effective; access to research on decision;
It would make me very nervous as I have been doing well on Remicade, I would be afraid it would mess everything up, it is hard enough going from GP to GI and having no in between support educated in both. This does give me a bit of anxiety. I know our benefit company HATES my med costs, and it greatly effects the rates, so I can see why they would want to make the change, but I think I would need more information before feeling comfortable with making any changes.

Je l'ai vécu avec ma fille. On avait remicade 300 mg aux 4 sem à l'hopital et l'assureur n'a voulu que le renflexis à 180 mg aux 8 semaines malgré les documents remplis par son gastroentérologue Besoin d'information principalement pour comprendre la similarité ou les différences par un pharmacien pourrait être bien
Knowledge about new drug, how it will affect me, what do do if it doesn't work for me (ie. can I go back to my biologic?)
Lots of information. To your question above: I do not have enough info about the study results or the new drugs to make any informed decision about this topic.
Medical studies proving effectiveness
More education.
More information. I'm in remission while on Remicade, what happens if I am forced to switch and go into a Chron's flare
Much is not known about these drugs and the impact that they have either alone or in combination with other medications (eg remicade and immuran, which they do not give in combination to boys anymore). Additionally, current companies provide patients with supports that are not provided by the provincial health system or bio-similar companies. Should the switch be made, are dollars saved really just passing other costs on to the patient which will then rebound onto the health system through poorer outcomes?
Need to know advantages and disadvantages to the switch. Would speak to my dr
No real concerns if they keep.me.informed of the new policy and procedures
Proof that it would not cause a flare up on me first
Proof that it would work the same as Remicade.
Proven studies that it won't impact my treatment .
Scientific proof form studies etc that this is a healthy choice for those affected   More sick days at work   Therapy to deal with the emotional effects of switching that impact stress levels and this affect IBD flares
Séance d'information sur les conséquences cliniques potentielles d'un tel traitement.
That depends, I would need to know for a fact that I will remain in remission. Getting out of remission will mean not being able to work, live normally and end up in hospital again. In the long run, that would cost much more than the price difference of my infusion.
The research that the bio similar I would switch to would be as effective.
Toutes ces réponses!
Understand the drug and it's affects.
Une étude qui prouve qu'il n'y a aucun effet indésirable et différent entre le remicade et son substitut
- financial help - Counselling my G.I - A person I can call for any questions, help to find solutions to any financial problems, taking care of your renewals, moral support, taking care of any problems related to the treatment.   - Having to go externally for blood test if not offered with the same services.
Aide monétaire pour continuer le traitement initial car ce type de traitement coûte très cher mais il est nécessaire.
All mentioned after e.g. with the addition of psychological support already not covered.

Assurance that if the biosimilar did not work that patient could be switched back.
Coverage, shipping, pharmacy availability, advice, monitoring
Financial
Financial
Financial aid through provincial exceptional drug status. Ability and option to get original medication (Humira) if bio-similar does not relieve adverse condition.
Financial assistance to pay for biological treatements.
Financial support
Financial support to choose my own form of treatment
Financial supports. I am covered partially by my insurance, but the remaining unpaid balance is covered by the pharmaceutical company. Biologics are very expensive, and I am not sure I could afford to pay $300+ every eight weeks.
GI consult Education Plan B if doesn't work   Payment/coverage discussions
I am having issues with coverage of my infusion medication. It would be nice not to have the hassle and stress of the money issue.
I am not sure. I need it to work. I really depend on my nurse's support every 8 weeks. Not sure I'd be this healthy after 10 years without her ... which would have cost the system WAY more $$$!
I am unsure of how the medication would be covered, delivered, administered, etc. I currently go to a clinic that has the medication for me there every 8 weeks.
If i switch from entyvio to remicade, it will bring back my disease. Aling with doc support, i will need financial support as it will impact my job
It isn't mandatory switching; the drug would simply be unfunded by the provincial HC system. That said, I don't think the gov should consider limiting coverage to a few drugs. Perhaps the gov could allow a "drug grandfathering", which still puts pressure on remicade to bring their damned prices down
It should be paid for by provincial or private payer, and I'd like to know every option in the similar categories with biologics, regular medications, etc so both my doctor and I can make a better informed decision together.
J'aurais besoin d'un soutien financier que le médicament soit couvert par les assurances publics et privés. Que j'ai rien à défrayer. Nous ne pouvons pas toujours remplacer les médicaments déjà existant. Je réponds mieux que médicaments originaux qu'au générique. Je n'ai pas besoin que le gouvernement se mêle de ma santé ! J'aimerais que mes médicins travaillent en équipe et non chacun de son côtés. Que mon gastro-entérologues soit plus flexible au effets secondaires ou au maladies adjacentes à ma maladie de Crohn. Que les services d'aides soit plus accessibles !! Pas seulement juste 1 personne pour tout le nombre de patient !
Je suis dans l'incapacité de travailler actuellement donc le régime public me couvre
Mon assureur ne paie pas pour mon Remicade. Je suis sur les doses de compassion.
monet fro treatment, receaving medication at home
Money to pay for the biologic that is working. Money for a psychologist. Money money money.

New financial help as the drug company itself covered the remainder of my medication cost since I couldn't afford it. Any new drug that costs anything for me would hit my low income budget. I would also need help getting medical leave from my work to deal with the change and help paying the expenses to visit my doctor two hours away more regularly while switching over.
Not sure...if it doesn't work for me financial assistance if I can't work?
période de transition pour au travail pour s'assurer que le traitement foncionne bien et pas effets secondaire, rencontre avec gastroentérologue et une infirmière.
Soutien finacier et l'accord de mo gastroentérologue
Support from the patient support program. Because ultimately I know my only chance to stay on the medication keeping me functional is the financial support for the cost difference between brand and generic.
Support with dealing with insurance and increased observation by care team to monitor for any changes. Possibly support for training if delivery system is different
Supports that would be needed would be disability as my child would not be able to work at her job. The current treatment of Entyvio allows to to function on a daily basis and able to go to work so that she can pay her mortgage, her student loans, her car payments, her groceries, etc. If she is forced to go on a 'less expensive' drug treatment she could quite possibly be unable to work. Which means that she would rely on the province to take care of her for the rest of her life. It is more cost effective to ensure the patients are able to get the medication and treatment that puts them into and keeps them in remission. Crohns patients are not guinea pigs for the government to 'try' cheaper medication on they are contributing members of society who are struggling with a debilitating disease that no one should have to deal with. The cost of meds that work for these patients outweighs the perceived costs by the provinces.
time off work to adjust to new meds and new side effects. Psychology visits (again) to help me deal with my trauma, counselling from my GI, more blood tests to see how the new med was impacting me
Understanding of financial impact and what the clear risks of changing.
Unknown.   If the new drug doesn't keep her in remission it's a huge cost to her health and the healthcare system
We haven't event gotten citrate free Humira yet. It will never be available at this rate — Imraldi is just as painful according to those in the UK who were forced over to it.
I would like legislation introduced that stipulates anyone whose condition does not improve or gets worse on the bio-similar should be able to have full coverage for the more expensive drug.
Probably all of the above. Last time we were switched to similar meds, they didn't work and the side effects were more.
I would probably need surgery or not be able to work any longer.
Likely the hospital because I would come out of remission

I feel that any change in medication causes massive problems in ulcerative colitis...if a person is in remission using a particular drug then would anyone be willing to start a flare by fiddling with medications for just a little saving ... I have a noticed difference in health between generic medications and the original ...that too in pregnancy related medications which happen to affect my ulcerative colitis...for example progesterone suppositories .
As long as same result no problem switching.
As long as the replacement works as well as the original, nothing
From the evidence I've read, there's no difference in efficacy when a switch occurs, and this mandate could save taxpayers significantly. Funds should be diverted to finding new treatments.
I would need the hospital as I don't think it would work
If it is safe, saving money is good for the medical system. Although mine is fully covered by private insurance.. But the doctor should decide if it's safe.
N/a - I am a pharmacist
No support needed at this time.
Yes
yes
Yes, it saves so much money. I was switched form inflectra to infliximab and had great results. I feel the research is there to support this and our more people could get on a great life changing drug.
Assurance that I can return to the old drug should i experience side effects.
C'est le seul médicament entyvioqui me convient pour l'instant. Je suis allergique (choc anaphylactique + séquelles neurologiques suite à remicad à tout médicament de la même famille) ... si on arrête Entyvio pour un autre et que cela ne fonctionne pas...par expérience risque que mon corps développe anticorps et ne pourrai retourner à Entyvio...il ne me reste plus d'options possibles
Counseling from our Gastro doctor as currently Entyvio is working and do not want to have a relapse if the drug has to change Been on remecade before and it caused liver damage and now she has hepatitis
Current treatment of entyvio is working incredibly for my daughter, it has taken years for her to feel a bit normal again. I fear she would end up on disability, unable to work dye to a change in drugs. She likely would need mental health issue support as this is very difficult on her emotionally and a change would be devastating. I feel she would require more appointments with her GI, nurse practitioner, etc as it would be like starting over in her treatment.
Déjà suivi
I would die.
I'm finally not flaring. It would mean starting all over. I've already failed renovate and simponi has saved me.

If the switch was made mandatory I would like the opportunity to plead my case to be exempt. I am finally using a biological that is working (after 3 years of going through hell) and I would fight like hell to avoid a switch- especially b/c there is the risk of not being able to switch back.
It doesn't apply to me as I am already using inflectra.
J'aurais besoin d'un suivi plus serré et d'une administration dans un centre de soin. Je prends présentement le Stelara mais j'ai fait de fortes réactions allergiques (choc anaphylactique) au Remicade et Humira.
Je ne prends pas de médicament actuellement
Je suis déjà sous Inflectra
Même soutien personnalisé qu'Humira (infirmière, accompagnement, soutien)
N/a
Na
None
None, I am already on Inflectra
None... Unless the injection technique was significantly different I don't foresee anything changing.
One assurance que ma remission continuera. N'etant pas capable de retourner sur remicade une fois stopper j'aurais un peu peur
Oui
Oui
Similar to Remicade (BioAdvance)
This is shocking news to hear!!! I have been suffering for years & only just started to get well on Entivio after only 2 infusions. The thought and stress of having to switch is terrifying! Ive gone through so much to get to this point, I cant help but feel like switching would be a set back. So yes all those supports would be needed along with sick time needed off work I suspect.
Yes
How come people who lives with gerd can't get treatment Humira stelara Remicade it's disease
Aucun
Autre
Infirmière pour expliquer le traitement et donner les injections de même faire le lien avec le gastro-entérologue, les assurances (payeur provincial et privé). J'ai pris humira, par la suite remicade et présentement stelara.
Lawyer up to sue the government.

Patient and Caregiver Comments – Additional

Doctors would need to be available To complete private plan insurers questionnaire should the biosimilar produced unwanted effects (in order for the patient To switch back to the brand biologic drug - however these cases should be exceptionnal)
I feel as though people should have a say in whether they switch or not. And there should be an appropriate protocol for switching back if the new medication doesn't function as well.
I want to know what they intend to do if the new bio drugs do t work for all of us. This is a scary problem as the ramifications of how sick I can get with out the proper medications are sever.
I would be very upset if the new drug they would force me to use did not work in the same way. I would like to know if that were the case would I be able to switch back?
Il est important d'avoir un médicament adapté à nous pour un bon rétablissement.
Il est important pour moi de continuer le même médicament même si le bio similaire est "similaire", je suis en rémission depuis plus de 15 ans et coûte moins cher au système de santé puisque je n'ai plus d'opérations chirurgicales et moins de visite et séjour à l'hôpital pour des complications et aussi beaucoup moins de visite chez mon gastro-entérologue et médecins et infirmière. Si le bio similaire est mal toléré ou moins efficace sur moi ou les gens qui sont forcés de changer cela risque de faire augmenter les coûts de nos soins médicaux et enchaînerait des coûts pour dépression et tous les problèmes qui découlent d'une santé physique non stable.
I'm, as a rule, a fan of less effective alternatives being introduced to the market, so long as, if they prove less effective in a specific patient's case, that patient can return to their original medication.
It's very concerning being forced to switch off of the one medication that has worked for me and kept me in remission for 5 years. I worry that switching I may have serious side effects like I did with humria (liver damage and congestive heart failure) which would make the biosimilars unusable for me and I wouldn't be able to go back to Remicade (since it is could cause an alergic reaction) with no other treatment options I would have to turn to surgery which would have a huge impact on my life.
Je comprends l'origine du désir des compagnies d'assurances/RAMQ de vouloir utiliser un médicament moins coûteux, mais je privilegerais le recours au générique pour les nouveaux patients, mais je n'obligerais pas les patient déjà en traitement avec Remicade de changer alors que Ça va bien... une rémission ne tient tellement qu'à un fil... et l'impact d'une rechute peut être si grave, jusqu'à mener vers une stomie par exemple, Changer de traitement alors qu'il est efficace et que je vais bien me procurerait un stress énorme
Je n'ai aucune idée en quoi consiste le changement de médicament. Si le moyen de le recevoir va changer ou pas; s'il sera aussi efficace pour moi, etc.
Le support psychologique manque énormément
Nous avons déjà un stress constant avec la maladie, que si un patient est en rémission avec un traitement pourquoi changer quelque chose qui fonctionne bien?
As long as it doesn't cost most for patients

Certaines compagnies de médicaments acceptent de rembourser l'écart entre le générique et leur original à eux. Ce serait peut-être une option pour les biosimilaires également?
Est-ce que la cie qui fait le produit biologique diminuerait le prix du médicament pour ne pas perdre ses clients? Est-ce que celui-ci offrirait un soutien financier pour combler le manque entre le remboursement du médicament au public ou au privé? Est-ce qu'il y a des recherches qui ont des données sur les conséquences possibles?
I have seen B.C. press release and feel confident with health Canada support.
I strongly support this initiative - we need the drug costs in this country to be sustainable and mandatory switching to biosimilars will save millions of dollars for the entire system.
I think the current costs are too high....if something can be cheaper it will help us significantly....
If Biosimilar medication can save money and have the same effectiveness then I am all for it.
If it works: support! Physicians should be careful not to make the error of believing everyone will see the same outcome.
If it's less expensive and equally effective I would have no problem switching drugs
It is been a year now that i am treated with Inflectra. I am good (rémission). But I have gain weight, like 10 kg in 1 year.
It would be nice to be notified well in advance of a switch.
Je dois prendre le tout comme ca vient!
Je suis contre les traitements à rabais pour le régime qui payent, on a tous les droits d'être soigné avec le plus efficace produit , a moins d' un choix volontaire par conviction et valeurs
Je suis d'accord pour essayer un produit biosimilaire lors d'une premiere utilisation, mais pas de changer en cours de traitement un traitement biologique qui fonctionne pour le biosimilaire. Ceci pourrait avoir un impact négatif sur la reponse au traitement et/ou sur le maintien de la remission. Il est deja tres difficile de trouver un traitement qui fonctionne. Un patient qui se fait changer pour un biosimilaire en cours de traitement et qui perd la reponse au traitement, pourrait ne plus avoir d'options de traitement.
Je suis satisfait avec les bons soins du salon invivable à St-Eustache. Merci à l'infirmière Estelle Roberge.
Jetais sur Remicade et j ai déménagé en Allemagne pendant 2 ans et je n ai pas eu le choix que de transférer sur Inflectra, tout c est bien passé, l'important est de bien inforyle patient
Keep up the good work
Non traitement fonctionne bien j'aurais peur de le changer
Provinces will have to mandate the switch.
Si les traitements sont des "génériques" des médicaments visés, il n'y a pas de problème, mais si ce sont des médicaments différents qui agissent différemment sur le système digestif, les symptômes des patients en rémission actuellement ont de grandes chances de revenir... Si tel est le cas, c'est impensable de faire subir cela aux patients concernés!
Traitements satisfaisants à date

Enforce I switched I would need siginificant consultation about side effects, bebenfits and ramifications associated with changing medications
tout va bien avec remicade je ne veux absolument pas changer de traitement
A switch should be initiated by my health care team no one else.
Afraid of a flare should a change be required.
Allow doctors to decide what is best for patients, not insurance companies trying to save a buck on drugs to have Ohip cover the costs of more tests when the drugs don't work.
As above, Remicade is expensive, but less expensive to the health care system then my hospitalizations, frequent doctor visits, counselling, missed work and income when I was sick/in a Crohns flare. Additionally, this medication has me in remission- a fully functional person in all aspects of my life. The prospect of messing with that progress, with the quality of my existence, is terrifying.
Auto immune diseases such as Crohn's and Ulcerative Colitis are terrible diseases to try and live with as they affect what you do. Needing to be close to a washroom limits what activities you engage in or what jobs you can do. The best treatment is needed to allow these individuals to function as normal as possible doing the jobs they love and living a life with a family should they so choose.
Because it is so difficult to treat it would be criminal to deny or force a change in treatment when you successfully find something that works.
Before Remicade my wife was in the hospital every few months with Crohn’s attacks where I had to take a week or so off work to take care of our children. It has been 13 years since my wife was hospitalized with her crohns. If it’s not broke don’t fix it should be the attitude towards long term patients who have seen great success and healing with the drugs they are currently using to control their disease. If you are new to the program and working through what works for you and what dies not then I agree start with the lower cost medications. But if you are on something like Remicade and it has given the patient and the family of that patient a greater quality of life, less stress and healing then it should not be changed. I know that finances are important in everyone’s life but so is the quality of life for the patient who has had tremendous increase in quality of life. They should not have to risk losing what they have. They drugs are marketed as the same but they are not, there are different proteins and parts to it. Who knows how this will react in each patient. Why sacrifice their quality of life and health?
Biologics are already highly complicated drugs - it is rare to find one that works right away and have little to no side effects. When one works - it is not safe to switch until you have rejected the drug - if you reject the drug ok switch to biosimilars but being on a biologic currently that has given me my life back is very scary to think I could be switched to a cheaper version my specialists doubt will take anyways. Had I started on biosimilars first - this would be another story however its not appropriate to change meds unless you are confident the biologic is no longer working / body has begun to reject. "Dont fix it unless its broken!" these are peoples lives here!
Bios are generally last attempts, in my experience all other medications were tried and this was a last resort

C’est déjà très anxiogène de prendre un tel traitement, je serais probablement inconfortable de me le faire changer pour un autre
C'est tellement difficile se stabiliser dans cette maladie. Ca fait 9 ans et je ne suis toujours pas stable. Me faire obliger un nouveau traitement moins onéreux me révolte et je trouve que c'est un manque total de respect envers nous les malades et ca crée un stress de plus
C'est tellement long et pénible de trouver LE médicament qui fonctionne finalement pour traiter notre mici que refuser de rembourser occasionnerait beaucoup de détresse. Ça serait vraiment un manque d'empathie désolant.
Changer de médicaments implique d’avoir moins d’options lorsque le traitement ne sera plus aussi efficace véritablement. Ça fait peur pour l’avenir des gens atteints.
Changes should be made by no one other than you or your doctor
Could this mean potentially less effective treatment based on cost? Seems full impact wouldn’t be seen for years to come and that is unnerving.
Crohn's and Colitis is different for everyone therefore treatments need to be different also. I welcome new therapies but I think it needs to be more about money to switch therapies.
Decisions should be made on a case by case. What works for one person might not work for others. This decision can quite literally make a crappy disease even worse. Entyvio works for my daughter, she now fears that a switch in medications will land her back at square one. People making these decisions should have to spend a day in a crohns patients shoes, then, maybe they would view their incurable disease in more than just dollars and cents, and see the courageous individuals who live with this disease each and everyday.
Do not force people who are already on the meds to change, rather start new patients on thrses meds. That way you don't risk taking someone out of remission.
Do not support this
Doctor need to listen to their patients and do what is best. Drug companies and the government dont do what is best for the patient. It is about the dollar not health care.
Doctors go to school to learn what is needed to make an educated decision on someone’s treatment. That’s who I want in my content when it comes to my care. Not a Third party who has not been following my care for the past 20yrs and has no business making medical decisions.
Economic cutbacks on life saving drugs should not be taken lightly. I know that Remicade has saved my life and that the switch to something different may affect my progress and quality of life. Please reconsider this switch and think about the people who rely on these drugs to live a healthy life.
Est-ce que les études ont également été démontrées chez les patients pédiatriques? J’aimerais voir les résultats des données probantes.
Étant atteinte de la maladie de Crohn, j’ai essayé à peu près tous les traitements possibles : Remicade, Humira, Stelara.. seul le Stelara réagit correctement dans mon cas. Si je sois encore changé de traitement, je crains de retourner à la case départ et que ce traitement ne soit pas efficace pour moi. Pourquoi modifier quand on a des formules gagnantes..!?

Finding a medication that treats your particular needs can be a challenge. Once that medication is found and helps you return to a “normal” life is priceless. As a patient, I live in fear that one day my medication will stop working. Knowing what that will do to me and the path I will have to take to find a new medication that works again is something I hate thinking about. I appreciate dollars and cents, but I hope there would be a consideration on how changing a med not only affects a patient physically but the also the mental toll it can take if the switch is not as equally affective as a “high-priced” medication.
Forced switching will cause a lot of unnecessary stress and anxiety for many people, symptoms of which can exacerbate symptoms of IBD. Forcing people to switch from medications that work to medications with unknown efficacy can leave patients struggling to find another treatment option, and is incredibly dangerous and reckless.
Forcing a switch seems to be a drastic action without counciling patients.
Getting the right medication has been essential for my health. I would not like ant to be forced to switch unless it was identitcal. Cost should not be the reason. Remaining healthy is!
Government should not arbitrarily be able to decide a patients best course of treatment. Quality of life depends on the right treatment as prescribed by a medical doctor
Government should not be dictating what treatment I need, that should be decided by my doctor
Government should not determine medical treatment for a patient
I am against forced switching to biosimilars.
I am all for saving money but medications is not the place where we should be switching around based on price. This could greatly affect patients already living with a chronic and sometimes debilitating condition by lower their quality of life
I am always nervous and apprehensive when a change in medication is required due to decrease in effectiveness. Having to switch medication for any other reason would also scare me and I would question what impact this would have on my disease especially if my current medication is keeping me in remission.
I am comfortable with being on remicade. I worry that the change would come with more side effects. I work a full time job and the lack or really bad side effects from the remicade help me continue to do so
I am doing well right now...LEAVE ME ALONE
I am very supportive of achieving value for money for the health system and protecting it for future generations, however, short sighted or knee jerk reactions in the pursuit of savings must be understood within the larger context of a patient episode of care. Biosimilars are only one part of the equation.

I do not understand why people who have currently achieved or are achieving remission should be forced to switch to a cheaper alternative, because once you stop using that particular biologic your body creates antibodies against the drug and it is no longer effective later on for treatment. Should the cheaper alternative not work for the patient then they have also wasted an option for treatment by switching. I believe newcomers to biologics should have to use the cheaper alternative and work their way to more expensive biologics in a trial by fire manner. I also think that once a biologic is no longer effective and a switch is needed that the cheaper alternative could be used also. I say those who have achieved remission should be allowed to stay on their effective treatments until they no longer work for the patient.
I don't have to take Remicade any longer since I had my colon removed. But if I did, I would be scared.
I don't k is very much about this but I find it very concerning that patients would be forced off a treatment that is working for them. Even if the new treatment works this can cause a lot of stress and anxiety. I'm currently switching over from remicade to Entyvio because remicade is no longer effective for me and the unknown of how the new treatment will perform has caused a lot of stress and anxiety for myself.
I don't want to switch to a biosimilar
I don't think people should be forced to switch. I think drug companies should be forced to reduce the cost of their drug
I don't think this should be "enforced" by provinces or federal. I'd prefer that my doctor counsel me on the right medication for my disease. I shouldn't have to suffer to "try" one that is different if my current medication is working.
I don't understand how you can take someone off something that is working and change them to something else. I've been on everything else as a repercussion of being on everything else I cannot go in direct sunlight for more than 15 minutes, I have peripheral nerve damage in my hands, arms, legs and feet and my eyes can no longer differentiate between the colors orange & red. Remicade is that only thing that has kept me out of the hospital and allows me to live and work.
I feel like if you're already on a medication and its keeping you healthy and in remission it's very scary to have to switch to something that may or may not work. And once you switch there is a good chance you can't go back. I feel like it fair enough if they want you to try the biosimilars first if you havent been on the others yet but not a full out change.
I feel those on biologics and I remission should be grandfathered and not be forced to switch risking their health, especially considering the limited treatment options for IBD and the severe impact of complications
I feel uneasy about this switch, especially because I am currently trying to become pregnant.
I find the amount of money they charge for these medications are ridiculous and should not be aloud but what can we do about it when you need a medication you need it.
I find this news incredibly upsetting. Messing with the health of many people is not ok any way you look at it.

I have a big problem with the provincial or private payers taking my rights and decision away on how I and my doctor decided to treatment treat my condition. These decisions should be between me and my doctor. The provincial and private payers will always take the cheapest way even if it is detrimental to the patient's health. Just as long as they safe a few dollars. People lives are worth more then that!
I have been ill with Crohn's since 2011. Early in 2012, after multiple failed med trials I was started on Remicade. It was the only medication that worked to keep my symptoms limited. I tried other biologic meds which allowed serious flare ups. It is wrong to treat human patients based on financial cost rather than medication efficacy. I will be hospitalized again if I am switched off of remicade. What costs more: a biologic or a revolving door at a hospital?? I'm angry at the thought of others not getting the help they need because someone decides not to pay for certain drugs. We are not check marks on a page. We are unique, living creatures who have unique journeys regarding IBD. Treatment choices should be based on best practice and made between patient and doctor, not the government or insurance company.
i have been on remicade for over 10 years now. The reasons why i don't even look into switching treatment is because it has worked 100% switching to something else could cause it to not work as well and my life is more important than just going on something that is cheaper.
I have experienced limited effectiveness and/or adverse side effects from almost every biosimilar and/or generic medication I have been forced to use. The prospect of being forced to switch to a biosimilar medication is horrifying; that I may be forced to switch because the government of BC wants to save money and the people responsible for making this decision have questionable familiarity with the actual experience of being dependent on such medications increases my anxiety about the situation exponentially. I am already a member of a vulnerable population; to further compromise my wellbeing by forcing me to use a biosimilar - not, I note, bio IDENTICAL - medication is yet another mark indicating how little the government of BC cares about its vulnerable populations.
I have finally found a medication that works! Since a bio similar is not 100% the same, I feel that it cannot be guaranteed to retain remission in patient. I think that new subscriptions could be a biosimilar. I'd also be worried about the cost since bio advance helps pay for it.
I have had 5 major bowel re-sections and have found remicade to keep me in remission. If I was forced to be on a far less superior drug in hopes to save the government money at the expense of my health and well being that is just so wrong in so many ways.
I have had great success on Remicade, would be too nervous to switch.
I hope it never gets there !! Being on a biologic has safe my life. It took many years to find the right medication.
I know that for a lot of people it takes them several tries on different medications before finding one that works best for them. Making the medication that works for them no longer available could really setback people's well-being.
I mentally can't afford to go back on prednisone in case of a flare up caused by the switch, this could go well but could also be devastating.

I prefer not to switch from my Remicade
I spent many many years bouncing from one drug to another and lived a very unstable life with repeated surgeries and the inability to maintain employment. Since I've been on Remicade, I've been able to stave off surgeries, and have been able to have a stable life. I am a full time university instructor now! I am seriously frightened that any alteration in my current medication routine could risk everything! Please don't do this without further research! Let us choose for ourselves!
I think all parties, drug companies, governments, and doctors have a responsibility to essentially save the lives of people and that no black and white solution will work. I have had crohn’s for 6 years and tried 5 different treatments. If I now have to switch after finally being in remission how does this help the system if we pay more for doctors and surgeries. Happy to try a bio similar treatment once this one stops working....until then don’t pull me off. It is really not right.
I think it’s ridiculous and unfair. I would be extremely upset if I were forced to switch to a less expensive medication.
I think it's best to stick with what currently works, don't mess with that
I think it's very helpful to have more drugs available in the market, as people respond differently and can find the best fit. I do not support forced switching, as this may lead to impaired disease control if the biosimilar is not as effective. And developing potential antibodies to Remicade may prevent me from returning to a drug that is currently keeping my disease under control.
I think patients being forced to change will create a lot of anxiety for them
I think this is very wrong and poorly thought out. Crohn's patients will suffer at the hands of a government trying to push these bio similars all in the name of money. My daughter suffers enough, she does not need to suffer the anxiety of unknown and real side effects from bio similars.
I worry the decision to switch is strictly being made on a financial basis and not a medical necessity. Remicade has kept me in remission. Will inflectra ?
I would hope that treatments with the greatest efficacy would be preferred and permitted. Care should come before cost.
I would not like to switch my sons meds after years of trying to reach remission
I would not like to switch to an equivalent biosimilar since my current biologic is working. I do not want to jeopardize my remission.
I would not support transitioning a person on a biological to a biosimilar during their educational years. They should remain on what has been proven to work for them until they finish college/university/trade school.
I would not switch medication with the hell ive been through.
I would not want to have to change from a treatment that is currently working, especially after it's taken a few different biologics to find one that works for me.
I would not want to switch from remicade to a biosimilar

IBD sufferers do not all fit under the same umbrella.. that being said, 1 drug may work for one person and not for the other
If a drug is currently working, it is stressful to have to chnage. I have found that Stress can have a major negative impact on Crohn's aymptroms and overall wellbeing. New drugs should be for new patients or for when something is not working for an individual and they need a change.
If a medication is working patiemts should not be forced to switch. People wait years to be in remission and this could put us back at risk
If a patient has been stable with no problems and they in remission for 19 years (me, age 60). My GI (and I) will be very reluctant to take a chance for on upsetting this.
If a patient is doing well on their current biologic drug why would anyone want to risk the patient possibly becoming ill again. It makes no sense for the sake of saving money.
If current treatment is going well, why switch it? That could be even more costly in the long run.
If I change medication, it may not work for me , most people with crohns or colitis have inflammation if their biologic 's work for them and me, don't make things harder then what we already go through on a daily.
If I was switched drugs I would be worried about relapsing since the treatments are not identical
If if works, then the cost is moot
If it works, don't change it. Generic is not the same as the real thing.
If patients find medications that work for them, no matter the disease, please leave well enough alone. People suffer until they get relief. These medications are a life line.
If scientific data say it’s safe to switch that’s fine, but that shouldn’t be up to big phrarma. Patients and doctors should be deciding on med changes. Not everybody is the same and some med changes could make someone sicker and cause undo pain, or cost them thousands out of pocket.
If something is working then why would anyone switch to something else?! What if the next thing doesn’t work and I can’t go back into previously working medications
If the government (either provincial or federal) forces patients to switch to biosimilars I would hope there is some sort of regulation/law that makes sure private insurance companies NOT force it on patients too. (or we would have to go abroad to get proper treatment).
If the government were to force a change to a biosimilar for only money/reimbursement issues, and that change causes a health issue in any way, I would be very upset to say the least and stay polite. Sometimes it takes years to find a biologic that works and gives remission. It's a shame to force people to change and possibly re-lose their health that is already fragile and easily unbalanced!! What money will be saved if that person gets sick again, needs surgery, can't go to work...?!
If the one we are already on changes our life after so much trial and error! Please don't let them risk the chance of a normal happy life.

If these bio similar treatments aren't successful to maintaining remission then there should be no reason for provincial regulations to force the change. Let people live a happy healthy life.
If you are currently on it and in remission you should just be allowed to stay on it until it stops working
I'm all for trying new drugs that will make it more manageable financially to offer to more - but this should be introduced to be patients and surveyed over time. Don't take people off of a medication they are comfortable with for years just to save some money when it could potentially risk their long awaited remission. Don't fix something that isn't broken. A lot of people could be put back into flares by switching medications. Let the patient decide.
I'm devastated by this news.
Impact on quality of life if bio similars do not work. More research Ned's to be done to ensure they work properly. I'm okay at reducing cost but not at the expense of my health, future health ie cancer due to scarring and quality of life
In my opinion this should be a decision that's made between doctor and patient...what's best for an individual patient based on their medical history and the expertise of the doctor
Insurance should not dictate course of action.
It does me because my daughter has had very severe disease with multiple surgeries, complications and impact to get life.   I would not want to take any chance of putting her at risk.
It is a hard to believe that my insurance is determining what drug I should be on and not my specialist.
It is incredibly frustrating to have this happen being forced to change medications even though it seems to be effective it would be incredibly anxiety inducing to be forced on a new medication when you have found one that works.
It is the doctors who should decide if a switch is in the best interests for a patient
It is very difficult to switch drugs. This disease is very sensitive to any and all changes. Flare ups can last for years and are very traumatic.
It is vital for my partner to receive remicade infusions regularly as the effect on her health is very beneficial. She currently manages her health and career well but any change could cause significant harm and a rapid drop in her health and wellbeing.
It should never be about money. NEVER. It should be about finding the best medical protocol for a patient.
It took a long time to find a treatment that keeps me in remission. I would feel very unsure about being forced to change to a treatment that will cause me to flare. I am already dealing with short bowel syndrome and I can't afford to lose much more intestine.
It would make me very nervous as it's hard enough to get into remission, but I see how costly the drugs are. Without more research or education switching would make me very concerned, especially as I am currently on two different biologics to treat crohns and arthritis!

It's bad enough we have to use biologic to controller Crohn's colitis, but to have it regulated like that is heart wrenching.
It's concerning that someone would be forced to change medications, especially if the medication is working. What if the new meds don't respond? Is all this worth the risk of a childs health?
It's getting stressful being on these high priced drugs. My plan at work switched and I wonder what's going to happen with these cheaper plans moving forward...
It's gross that a well working current treatment that helps some may be lost bc the province or private healthcare wants to cheap out
It's worrisome to think Provincial funding or insurance companies could dictate a patient is only covered for a less costly drug. I'd think this would limit options for those who find a drug doesn't work well for them and that is unfair. As a mother of a child who will be dealing with this for the rest of his life I'd like to see more options rather than limits based on cost.
Its all about the money honey..not the patient experience.
J'aimerais savoir si nous pourrions trouver un moyen pour nous éviter de toujours dépendre de nos médicaments
J'hesitera À changer
J'aurais probablement ume augmentation de la crainte de retomber en phase active.
Je crois que j'essaie de changer peu être complètement de médication si ceci est obligatoire
Je crois que lorsqu'un traitement fonctionne sur un patient, c'est signe que nous sommes sur la bonne voie. Changer pour un médicament moins coûteux est selon moi, un risque pour notre état de santé. Pourquoi changer une formule gagnante ? Nous souffrons assez des conséquences de cette maladie.
Je refuserais de passer sur un générique
Je suis à la fois patient et aidant ma fille et moi avons la maladie de crohn trait'e Sous remicade. Il est tellement difficile de trouver le bon traitement/ dose fréquence pour contrôler cette maladie; svp nous laisser continuer avec le médicament qui fait effet dans changement
Je suis en rémission depuis remicade (2010), je serais en colère et inquiète de devoir changer un médicament qui fonctionne à merveille. Je n'ai jamais eu une rémission aussi longue
Just the stress of being forced to switch to something else that has no guarantee of working especially after being in remission as a result of the remidcaid would more than likely cause a relapse before the medication even got changed. My crohns affects my eyes and I'm not willing to go blind due to another relapse. Somebody playing Russian roulette with my vision is not ok.
L'équilibre étant très précaire dans le traitement des MII, et l'état de rémission si fragile, je serais très angoissée de devoir changer de traitement
Le prix? Est-il possible que la pharmacie nous en refile déjà sans qu'on le sache? Quelles sont nos options si jamais notre système rechute après la prise des biosimilaires? Comment prouver que la rechute vient du biosimilaire et non, un hasard? Pourquoi changer une formule gagnante :(

Le Remicade fonctionne pour moi depuis bientôt 6 ans. Un changement de médicament me fais peur car je ne voudrais pas rechuter
Le service des programmes patients doit être moindre avec les bio similaires à cause du coût moins élevé ?
Living with this illness can be extremely difficult at times. Finding a medication that controls your illness is priceless; it changes your life for the better. Being forced off of something that works (and it can be a long, painful road to have found that in the first place) to experiment with something potentially less effective all in the name of saving money is something I pray to never have to endure. Quality of life is EVERYTHING.
Many people struggle finding a medication that works for them. If you are forced to switch to try another one, with no route of going back if it's ineffective, could put peoples life at risk.
Medical treatment should not be determined by only monies funded.
Mon fils de 14 ans a été mis sur le Remicade après un échec de la prednizone dans le cas d'une colite sévère. Il. En 48 heures, tous ses symptômes sont disparues et depuis, il est en rémission. Il a repris l'école, les sports et a retrouvé une vie normale. En crise, il n'avait plus aucune qualité de vie. Aucune envie de changer de médicaments en ce moment...
My course of medication is working right now, so MANY over the course of my disease did not. My concern is my overall health and if this medication does not work, it would set my healing/remission back. Interruptions to my treatment are not advisable.
My daughter lives with Crohn's and is very scared of the side effects of drugs on her life. She wants to make sure that whatever she takes improves her well-being overall and does the least amount of damage.
My gastroenterologist and GP have advised against switching or discontinuing my current treatment. I would be at a very high risk of harm or complications.
My son has tried many medications for years and has developed antibodies and severe reactions to medicine. Switching medications would be very negative for him. If he develops antibodies to the new medication and can't go back onto Remicade due to his body rejecting it. My son is 18 years and has a full life to live with this disease. I hope that he gets to stay on the medication that finally works for him. And not switch to another medicine. This not in the best interest of the patient.
My son is responding well to Remicade and I wouldn't want to switch him to something that has not been proven
My son was diagnosed with ulcerative colitis at 9 he is now 17 and has been in full remission for approximately 3 years. We were lucky and did not have to use s biological but it is only inevitable that one day we will have too.
Need this medication
No
Non
not impressed
Nothing

On ne change pas une formule gagnante
Only a physician in consultation with a patient should be making these decisions. I agree that lower cost alternatives should be offered as a new product when new products are being considered by a dr/patient, but it would be immoral and inhumane to take someone off a drug that is sustaining remission, potentially causing severe illness to return and insurance coverage being denied, for the sole purpose of saving money. I am currently provided with 100% coverage for Humira from Progress for my LIFETIME and am in my 8th year of remission. Prior to that, I had 3 separate surgeries including at least 3 mall bowel resections, lymphnode removals, a small bowel bypass, too many blockages resulting in emerg visits and hospitalizations to count, 3 mths of liquid diet waiting for surgery for a 90% blockage, endless pain and prescriptions, and oh yes, let's not forget the heart attack amidst all of this...
Our medications are severely overpriced to begin with. Changing a person's medication due to cost lowers chances of remission and increases other bodily reactions including long-term new illnesses (organ shut down, cancer etc). The government should not be dictating which medications work for my condition.
patients should have choice as to whether they want to switch, lack of choice diminishes patient dignity.
Patients should not be forced to switch if their current treatment is effective. Not fair to be treated as guinea pigs
Patients should not be forced to switch to a biosimilar if they have good response to the originator and are in remission. The potential risk is not worth the immediate savings if the new agent falls short
Patients should NOT be forced to switch treatment when it's working.
Patients should not be forced to take a potentially less expensive medication because someone without a medical degree decides it based on funding. Health should not be a budget item, and Drs should be able to prescribe the medication they feel is appropriate without needing to push for coverage.
Patients shouldn't be forced to switch
Playing with medication like this feels a bit dangerous to me. This might be the only thing keeping someone from a flair and they want to change it because the other one is cheaper? When they talk about this happening it almost feels like they don't care about the patient just about how much money they have to spend.
Please don't allow this to happen
Please keep advocating that medical doctors should still be able to prescribe what they know is necessary for their own patient on a case by case basis rather than sweeping switch to biosimilars. Also what will be in it for big Pharma to keep researching for new meds if they lose significant sales to biosimilars? Why invest all that funding into R&D?
Please please strongly advocate against this change. I understand wanting to save money but politicians and insurance companies are gambling with our lives. They aren't the ones that have to struggle to get to work wearing an adult diaper.
Politicians shouldn't prescribe my injections

Pour les patients dont l'efficacité des médicaments a généralement été pei concluante dans le passé, est-ce que le fait d'être forcé de changer de traitement, maintenant qu'on en a trouvé un qui aide un peu, pourrait faire en sorte que le nouveau traitement soit moins efficace?
Quand tu es stabilisé, tu ne veux courir aucun risque, tu ne veux pas rechuter.
Rather not switch
Remecaide was the last option before surgery, and it's the only thing that's worked. Switching from something that works is very concerning if there isn't a need
Remicade has been a saviour and if I am forced to switch and it doesn't work then my life would be hugely impacted... not fair if that choice is forced on me
Remicade has made a huge difference for me. I'm now able to live my life most days without fear of having an accident and without being in excruciating pain from all the inflammation in my body. If I were suddenly denied this or forced to switch, I fear it would have catastrophic consequences on my body.
Remicade has put him in remission for 4 years. Able to attend medical school.
Remicade is the only drug that I respond to. Without it I would be unable to continue my post secondary education and work.
Remicade is the reason why I didn't have any symptoms for the last 10 years. I'm really afraid to change medication. I don't want to be sick again.
Remicade is working for me. I should not be forced to change drug because it's cheaper.
Remicade me permet depuis 10 ans d'avoir une vie normale. Ce médicament est miraculeux pour moi et pour tellement de patients. Pourquoi prendre le risque de ruiner la santé des patients? Avant de trouver Remicade il m'a fallu 3 ans de douleurs et de rendez-vous à l'hôpital pour trouver LE médicament et là ce sera peut-être à recommencer? Être malade et souffrir de nouveaux ? Depuis 10 ans le Remicade me donne une vie normale.. pourquoi risquer de rendre des gens malade ?
Rien de particuler sauf que ceci semble une mauvaise nouvelle (je suis un patient stable sur Remicade).
See above
See answer to question 8. It is scary to have to go on any medication this strong, let alone having to restart onto another without a real reason.
Should be patient specific
Should not be forced to change due to cost. Remicade is keeping patients in remission.
Should only change if in pts best interest.
Si le Remicade, dans mon cas, fonctionne bien, je ne vois pas pourquoi je devrais changer quoi que ce soit!
Si les études démontrent que les nouveaux médicaments seraient bénéfiques, il faudrait tout de même que l'administration de ceux ci soient bien encadré.
so many crohns meds do not work and if a patient is on a med that is working for them it should never be switched as that med may not work in the future for them

Sometimes it's not about saving money. Quality of life for people living with IBD saves so much more money than a "simple" medication switch
Suffered from Crohns for over 20 years and been on Remicade for 9 years and have been in remission for those years and wish to keep it that way no have no desire to switch.
Switching medications shouldnt be done just for cost effectiveness; but should be done for the benefit of the patients health and treatment plan.
Thank you for making this file a priority. I find this whole situation very worrisome and fear being forced to change my treatment plan when my current biologic (3rd one I've been on) is finally working so well for me.
The Biologic I'm on has been working for two years! The previous 16 years I had been in a constant flare... I know I only have at best four more years before it stops working, but taking those years away early due to being a cheap ass government will be life changing and a form of torture that is preventable. Mind you, I could probably start a class action lawsuit and sue the polititions and gov that tries to do this!
The current state of provincial politics is frightening. National is not much better as I fear the far-right will be fear-mongering to bolster support from the uneducated and uninformed.
The government and corporate insurance has no business in my treatment plan. My health is not a game of trial and error.
The high risk mixed with few treatment options mean that *no one* who is currently being treated with a logic should be required or forced (financially, pressured, swayed, etc.) into switching to a biosmilar treatment option.
The idea of a forced switch is ridiculous. Just thinking about this possibility scares me to no end.
The medical requirements for an individual should be determined by the attending physician and patient. The government has no place in this conversation.
The medication is working leave it alone.
The only persons making these decisions should be the medical practitioner and the patient. A politician and an administrator cannot possibly make a well informed decision on this matter. People's lives will be adversely affected by solely cost cutting measures. Any persons enforcing this potential change in treatment should be liable for the serious and possibly irreversible consequences. Undeniably unnecessary suffering!!
the option should always in the end be the patients
The risk, if one were to switch to biosimiliars only for it to prove ineffective and then potentially build up.sntivodies or become non responsive to the original biologic is very high. This is my biggest concern along with original biologics no longer being covered by health insurance in favor of the cheaper biosimilars.
These kinds of forced changes or decisions should not be made by insurance payers but by doctors only.
These types of changes should be primarily made if the treatment change does not negatively impact the patient. The costs, even of the biosimilars, are very significant and unaffordable
This cannot happen. Don't fix what isn't broken! Ive been on Remicade nearly 10 years.

This concerns me- a lot
this could increase the costs in other ways - saving money to diminish someone's quality of life is counter productive
This disease sucks!
This is a horrible idea. People should have their choice of meds. Not have it forced upon them when it takes so long for IBD meds to become effective. It stressful, it's scary and that piece of the puzzle plays a huge part in IBD health. Don't mess up our piece of mind.
This is absolutely ridiculous and outrageous, NOBODY with crohns or colitis should have to abandon a drug that is making them feel better, getting into remission is very hard and if the drug we are on is working and has us in remission we should never have to switch medication. NEVER.
This is morally wrong.
This is my 4th biologic in 6 years and I am finally in remission. It terrifies me switching to something that could cause a flare. When I am in a flare, I have 15-20 BMs a day, which causes depression and anxiety. I cant work, I can't go out, I cant live. Why they would play God with probably thousands of people's live is beyond me.
This is not a good idea!
This is potentially detrimental to people in remission due to use of biologics. This risks the new genetic not working the same and development of immunity for a drug many people would have worked long and hard to get the patient to that remission or stabilization point. It may say drug costs but may be more costly in the long run as patients may need to start the whole process again to try to find a drug that works.
This is ridiculous. IBD is already a hard disease to handle, finding a good working drug for some people is already so hard, now forcing them to switch to cheaper drugs that are “similar” is a gamble. IBD is already on the rise. Why risk people’s health for cheaper drugs... that may not even work... and bring people back to flare ups, hospital trips, more anxiety just for cheaper meds.
This is ridiculous... I support biosimilars being offered as treatment but not forcing patients doing well on their drugs to switch. This will only cause many people to become sick and they will not longer be able to go back to their old drugs.
This is terrifying for people with long term Crohn's with major complications, ie fistulas. Nothing is as effective as Remicade,
This is truly frightening for a lot of patients and I’m counting on organizations such as yours to help advocate for patients
This is unacceptable given how long patients suffer in the process of trying to find a treatment that works for their disease. I don’t respond well to generic products and I don’t want to risk my health. If it’s working leave good enough alone!!!

This is very scary and May have an enormous, life changing impact on patients. Those lucky to go into remission as a result of their medication are at risk of getting ill again which may lead to the roller coaster ride of having to find a medication that works or another surgery. This is very upsetting news. Again the government is putting money ahead of a persons well being.
This is very scary for patients who have tried various treatments and a biologic is now working. Why jeopardize a patients health by playing roulette when the disease itself is bad enough.
This makes me angry. If you switch and the medication doesn't work as well or doesn't work because of your body chemistry you may never be able to get back on your current drug, as your body may not accept it
This scenario scares me I don't see how switching from a drug that works for me to a drug that may or may not work is worth the risk to my health or quality of life I worked very hard to be in remission I wouldn't want to jeopardize my health by making unnecessary changes
This should not be forced. The most effective & best treatment should be what is prescribed - not what the cheapest is.
This would be a disaster mentally and possibly physically.
Thus messes with people's quality of life!
To be taking such liberties with peoples health who have a lifelong diagnosed disease without proper research and information is selfish and irresponsible. Many people such as myself have gone through multiple surgeries, various rounds of medication and testing only to have eventually found a drug that gives us a certain qualify of life back. To jeopardize this without absolute certainty the biosimilar will not hinder our progress in any way is extremely upsetting.
Une clause grand père devrait s'appliquer pour ceux qui reçoivent déjà le traitement remicade et pour les nouveaux patients le bio similaire. Merci
Very scared that it won't work as well for my daughter. It has helped her so much. Hardly any flare ups with Remicade.
Want to stay on current drug It should be the doctor who chooses what's best for the patient not the dam government
We cannot know whether bio similars will work for everyone, and if they fail, whether the initial drug will still be a treatment option to go back to. With so few drug options already, it should not be an option to force patients to change. Surgery that may result from losing remission will cost the government more than keeping patients in remission.
We should have a say in our change in our medication.
When did the province become doctors to dictate what medication I should be using.
When it comes to this disease, even small changes can cause a flare up. If a person is on a med that's working for them don't change it.

When you have Crohn's, finding a treatment that works after suffering from pain and diarrhea and a fistula and weight loss and then being told you need to go on something "cheaper" is both terrifying and possibly dangerous.
While I understand that cost is an important consideration I hope that the most important criteria should be patient health. If the cheaper treatment doesn't work the patient should be given the one that does work.
While I understand that this may reduce costs, for myself, I will avoid biosimilars. Part of this is the due to the infusion center and the medical staff that I work with.
Why are we taking steps back? If drugs are working for people, leave it alone.
Why mess with something that is working so well? Remicade has put my 7yo daughter into remission and I fear changing the med even if it's just the generic version may take her out of that remission and I've heard that once you go off of Remicade the chances are high that it won't work again. Why not treat all new patients with the generic version and keep all the patients who are having success on Remicade on Remicade.
Without definitive proven effectiveness, there should be no consideration of a forced change. People living with these debilitating illnesses, and those of us who have to provide care do not deserve to be forced into less effective treatment by any government mandate or insurance consideration. If anything, government should impose regulations on the providers of the drug to disclose their overhead production costs and impose a maximum profit threshold.
Would not be willing to switch ever. I was told by our son's GI that if he ever were to go off, the chances that it would work again would cut to less than 50%. I will it jeopardize switching to a biosimilar.
would not like to be forced to change from Remicade when it is working for my son
I've only been on Inflectra. Never taken Remicade.
I don't object to the use of biosimilara, in fact I support their use in a hopeful way to bring down the costs of existing biologics (Humira & Remicade). However, I do NOT agree that any patient should be forced to switch. They can be informed of the potential, encouraged to switch, but never forced. Also, under no circumstances is it appropriate for them to be switched without prior knowledge.
I don't think it's a bad idea to start new patients off on biosimilars, provided that the science is there to support that they are safe and will work. But, for those who are already in treatment, it seems potentially unsafe and I am opposed to it.
I feel that for new diagnoses, beginning on a treatment with a biosimilar could be appropriate. Once a patient has been taking the original biologic, there is just not enough evidence to support that changing to the biosimilar would not impact remission status. I would be afraid that it could mess up the body's response entirely.
I think starting new patients on a bio similar is feasible but there is absolutely no way a successful treatment program should be switched. The risk of remission is too high. Also, quality of life is precarious even with successful treatment - it is not fair to ask patients currently on biologics to make a switch.

I understand the use of biosimilars but it should be for those where biologics are not working or for new patients, having those of us switch is wrong. I've had Crohns for over 30 years and it took 20 years to find a drug that worked. All IBD patients are different, you can't group us in one category. My question is: if I have to switch and the biosimilar doesn't work, can I go back to Remicade??
I understand using a biosimilar for new patients but I fundamentally disagree with switching a patient from an existing biologic to a biosimilar just to save money. It just seems cruel to mess with people like that to save a buck.
I'm absolutely not in support of forced changes for patients currently using remicade etc. I'm 100% in support of using the biosimilars if someone is starting it as a new drug. But given that a person often can't return to a previous drug once they've changed, I wouldn't want to see anyone switched if their current medication is working. There isn't nearly enough available drug options to start playing around like that. What would happen if the biosimilar wasn't effective for that specific patient for some reason and then they had issues returning to what did work? Not good. Also, I'm well aware Crohn's patients alone already cost a lot for the health care system, but I can't help but think messing up treatments that are working well would potentially cost just as much or more? Aside from the misery it would cause the patient... That being said, if the specialists all thought 'this will be no problem!' Then I could be convinced. But I wouldn't be willing to risk my health if it wasn't a 100% chance of working the same way.
Rather than make existing patients switch, province/insurance companies should ask patients to start on biosimilars (unless a gastroenterologist specifies the original biologic must be used). Remission takes so much time and work, and there's so much pain involved in active disease. Don't mess with what works!
Until there is a wide scale study to firmly support the use of biosimilars, precaution should be taken for patients who have been on innovator drug treatments since adverse affects may occur. New patients being diagnosed could explore the use of a biosimilar much easier than patience like myself who have been on remicade for 10+ years.
I just want drugs that don't hurt or cause anxiety.
Not sure
Are the side effects the same? Is there enough research done?
Comment s'assurer qu'il n'y aura pas d'effet secondaire, ou de rejet du nouveau médicament?
I believe switching could cause more allergic reactions in some people. The drug could also be less effective
I don't know anything about the research so it's hard to know whether to be concerned or not. The concern would be that this is being rushed to save money for insurers and proper long term research hasn't been completed.
I feel if they want to use biosimilars then they need to do more research and figure out why they are failing these poor patients (before they force the patients to make the change)!
I feel there would be a higher risk of allergic reaction to biosimilar.

I have had some reactions from biologics in the past, I'm concerned that biosimilars will cause serious reactions.
I have not heard about this before. Curious what it would mean for someone like me who has had good luck with my current medication.
I was on Inflectra and not remicade. I had to stop because of side effects with my breathing and brain! Wonder if it would have been the same for me on remicade?
I would hope that a discussion was made first before showing up to an appointment to find out they have switched my medication
I would like more information on this subject
I would like you to keep us inform
I would need more info
I'd they make the switch some people die and some people just go back to before three got Remicade because bio similars do not work and if they do work on a Crohn's patient it's usually much less effective than the original patented Remicade. This has happened all over the USA already with disastrous results destroying many lives. Why would we think of doing this Canada ? This is losing public healthcare and allowing private healthcare drugs that don't work as effective take over !!!
I'm really concerned that a biosimilar might not be as effective as a biologic.
If research shows the biosimilars are not as effective I don't think that anyone should be forced to get inferior care because of the cost. I would hope that the manufacturers of the biological treatments would provide funding to stay on their meds. It would be nice to have other places to get coverage as well.
Il serait peut être agréable d'avoir une session d'information concernant les avancement des nouveaux produits et des essaies ect...
Informations détaillées du médicament, effets secondaires, effet à long terme sur ma santé en général,
Is this for real???????
It would be beneficial on the survey to share what the difference is between the drugs other than one is cheaper as this is the first I've heard of this.
It's not 100% how I would react to a new medication. The medication I'm on now treats some of my side effects that biosimilarals don't.
Je crois que ça prendra de très bonne explication et une assurance que le traitement sera la meilleure solution
Je ne connais pas assez l'impact de ce changement pour l'approuver ou non. Il faudrait plus de détail.
Newly diagnosed so not enough information yet
Please disclose studies on the effectiveness of these biosimilars.
Réviser votre position devrait uniquement se baser sur des faits médicaux, des données et des résultats... non pas sur l'opin De vos membres. Faire une capsule pour nous donner de l'information À ce sujet serait génial

The brand names are so very expensive that it would be nice if there was a cheaper version but I know generic brands or bio similar do not always work as well as brand names. Sad that people who have this disease have medication that is so very costly as we have not asked for this and it affects life so much.
The switch should only be made if enough research supports the high probability of success... Each IBD patient's profile is individual, many have gone through trial & error of many meds before finding one that WORKS for them. Personnally, I'm finally stable and I don't feel like being on a "gutsy roller-coaster" once again, so if anything changes, I certainly hope my chances of staying stable are high!
There is sufficient amount of research that's been done to warrant a switch. From my readings I've heard that bio similars are not as effective.
There needs to be more support for patients and their families. And more public info about IBD
These are not like Normal "generic" medications, Forced switches should not be allowed when that medication is the only thing keeping you healthy
This is the first I have heard of this. Makes me extremely nervous...
This should not be allowed unless evidence based research consistently proves that switching will not cause any harm and will provide the exact same benefits of current medication
Very concerned that there is very little research or concrete findings on the risks of switching.
Veuillez nous faire part de tous commentaires supplémentaires que vous pourriez avoir.
Would hope there's enough research to support a switch and what percentage of patients remain in remission post switch and how many flare? I would need to know who the switch would be good for? Mild, moderate or severe disease.
Would like info on the results of research on patients who have switched.
Would like to learn more about this potential switch to bio similar treatments
Would love to hear more .
A switch of medication to a cheaper one should never be the way to look at a persons health. You cannot put the price on someone's health. If the medication is doing it's job then leave it alone. If it doesn't work then switch it but not before. The government has no right to tell me to switch medication just because it's cheaper. Will they pay the price of my health failing? No I will and I'm not taking the risk
Although the biologics are expensive to manufacture, IBD is more prevalent across Canada every year and it isn't fair for those of us who suffer to be denied quality treatment. In my opinion, the government should be covering some of the cost of the biologics as it would be cheaper than the cost of patients utilizing the healthcare system more than a healthy person does.
big concerns about financial assistance
Can I take away something life changing from "the man" and substitute something cheaper?

I am very disappointed with the Ontario government switching to biosimilair. My 9 year old is on remicade and currently gets companionate care and we pay dispensing fee. $12 seems like not Lot but add time off work,.parking, etc adds up to a lot. I also have a 2 year old with the disease that may be on remicade or biosimilair in the near future.
I can not afford humira and other main stream treatments.
I live in fear I will no longer qualify for assistance and not get medicine. I am afraid I'll be on this the rest of my life.
I may lose my coverage at some point and that worries me a bit. I may be forced to try the lesser priced one.
I think I said it in my last post but I will reiterate. You have no idea what changes in our medications can do to our bodies. We are all different. DO NOT SWITCH STABLE PAITENTS!!!! New patients can start on it, that is smart. I get it.
If a cheaper drug were to become available to me, my health insurance would probably force me into taking it or they would deny my special authorization.
If I have the option to pay, for example, via private insurance, I would like to be able to do so if needed.
Je trouve triste que les gens malades soient hypothéqués monétairement. Une chance que les assurances couvrent Remicade. J'ai une qualité de vie maintenant.
Même si le médicament coûte cher il devrait être gratuit pour tous.
My daughter was on multiple biologic treatments which didn't work for her. During that period she was off on maternity leave and told BC Med wouldn't cover the total cost and she would have to pay an outrageous fee for the medication. After multiple phone calls to her G.I. specialist she did manage to get special fund by the government and her fees were reduced to $0.00. The whole ordeal her her under a tremendous stress and seamed to escalated her condition. I'm disappointed the way the medical system in this province treated her......
Should be a national pharmacare plan so the government can negotiate price of medications with pharmaceutical companies - ex. New Zealand (government negotiates price with pharmaceutical companies and prescriptions are $5 each for the citizens)
The cost of Remicade is KILLING my personal medical benefits. I am 43 and will run out of my benefits by the time I'm 46-47. My personal benefit amount is $1 million dollars - let that sink in. So medical benefits that the average person won't use a quarter of will be done for me and I will have 20 years of paying out medical coverage (unless something changes)!
This is hard enough, playing with our medications because of dollars is so frustrating
This is where we desperately need government intervention and advocacy for capping big pharma on drug costs! A costly drug like Remicade has helped our daughter tremendously with severe Crohns. It's not right that big pharma gets away with charging $1000 per unit of this med.

This proposed change could make medication more accessible to those with no insurance coverage. If there is a marked difference in the effectiveness of similar drugs, there should be a process by which individuals can use the drug that gives them the most relief.
I really don't think anybody should switch their medication while on it; maybe new user of biological treatments could start with « generic »
What it it doesn't work...???
At the beginning my infusion medication was working well, but it seems it's not working as well anymore. Maybe a change could be helpful!
Cost is a big aspect.
IBD changes people's lives. Having more options available to patients is not only helpful to their mental health (knowing there are alternative treatments) but also science tells us that different medications work for different people.
Inflextra seems to be working to a certain degree for me.
A switch after 8 years would cause extreme anxiety. It took a long g time to be comfortable with Humira, I can't imagine the stress it would cause physically & mentally if a switch was forced.
Après 16 de purinethol je revit avec l'entyvio
Après presque 15 ans de souffrances de toutes sortes, Humira a changé entièrement ma qualité de vie. Depuis 2 ans sans rechutes. Changer de médication remettrait tout en question...Je ne souhaite pas revivre de pareilles années invivables !!!
Been on Humira for 9 years. Seems to keep me okay so don't want to rock the boat! Other treatments did not work
C'est vrai cette histoire? Humira est mon médicament!!!! Je ne peux pas le croire...
En étant en rémission depuis 6 ans en utilisant Humira j'au Une grande crainte de changer pour bio similaire et faire une rechute à ma maladie La preuve est faite pour moi de l'efficacité d'humira dans mon cas
Entiviyo has changed my quality of life. It has completely put me in remission. Before this I was taking 12 pills a day including steroids to control my symptoms. Now I just take Entiviyo and live a normal lifestyle
Had to switch off humira due to medicinal allergic reaction

I actually strongly disapprove of the idea of drug companies forcing a switch or private insurance forcing a switch. Living with a disease like UC/CD is so incredibly difficult, and finding a new medication is incredibly tough. For me, I built up antibodies to Remicade and Humira didn't work so I went through a year of horrific pain and side effects plus getting actively sicker and eventually winding up in hospital in which I was considered for an ostomy as my disease had gotten so bad from Humira not working. Currently, stelara is working for me so far (at least I'm not symptomatic - waiting for bloodwork results to find out if it actually getting closer to remission) and the reality is that if someone forced me to switch for cost-saving measures, I could likely end up going back to hospital, losing my job, my house, my car etc. But more than that, this isn't cost saving long term for the government. First of all, every night I spend in hospital is around 1500$, assuming I don't have insurance, this comes out of the taxpayers pocket. Secondly, a bed is wasted on someone who could be healthy if a province didn't make a political decision to save money on the backs of peoples lives/health. Thirdly, assuming I lose my job because of the health issues I will then have to file for whatever EI I have left (which won't be much after this flare), and I'll likely end up taking on welfare if I can't get better soon enough or find a job quickly enough after my flare. At the end of the day, this quick fix to save money actually holds a huge risk of saving zero dollars, putting others health at risk, and requiring us to switch back again to the initial drug after more expensive tests to ensure the other isn't working. Finally, a point on bodily autonomy. The reality is with a chronic illness that is internal to your organs, there is a lot of issues with not having the capability to say no to certain things you'd rather not to - mostly because colonoscopies are the best way to diagnose a flare. Choice is integral to our overall health and mental health as patients. any government that wants to limit choice in a developed country where the cost shouldn't be (and quite frankly isn't an issue for the Canadian government) an issue for health outcomes is an incredibly awful thing to do. To me, and I'm sure to many others, this shows that the government doesn't really care about what you have to go through to save a few dollars. If you asked me to do something simple, like file a few more documents, or take an extra driving test after my glasses prescription changes every few years, I wouldn't be happy, but it would be feasible and long-term wouldn't affect me personally too much. However, the tests you are ensuring will happen more often are things like: CT scans, MRI's, bloodwork, colonoscopy, at-home stool samples (which are a special type of hell if you haven't done one yet), barium swallow tests, x-rays, ultrasounds, colonoscopy's, sigmoidoscopy's and endoscopy's/scopes to name a few. All of these tests are honestly pretty painful when you're sick and invasive as all heck. Further, they come with a serious risk of cancer and other side effects if you have too many. The reality for us with Crohn's is that we already have had too many CT scans (I have had three this year due to a flare). It is integral that governments respect our bodies and do not put us at risk of losing our health or harming us further. Please, please, fight against this on our behalf.

I am concerned that people who switch from Humira to a bio-similar may damage their remission. When I stopped using Humira for even two months at the end of my pregnancy, the drug never worked as well when I resumed my treatment. It would be fine with new patients who have never taken a biologic start with the bio similars and only switch if those treatments don't work, but I believe people already taking the original medications should be "grandfathered in" and allowed to remain on their treatment plan with full coverage. To do otherwise could be harmful for people's treatments plans. I now have to take 80mg of Humira weekly, which is much higher than the recommended dose of 40mg biweekly. This is expensive, as coverage plans will only cover the recommended amount. Abbie Care sends me the remainder for free. Thank goodness. Obviously, switching to a bio-similar would be advantageous for all parties, myself included. However, since cessation of Humira for even a short time negatively impacted my health and treatment options; I am scared what might happen if I move to a bio similar for six months or longer that ends up not working. What if Humira is even less effective after that? What will I do? How will I continue to do my job effectively as a high school teacher if I have to be running out of the classroom every twenty minutes with bowel urgency and pain? How could I be a supportive mother and wife if I was exhausted all the time and in and out of hospital? If not effectively treated, my Ulcerative Colitis could have drastic negative consequences on my life. Put simply, I'm scared.
I am currently on Entyvio and thankfully do not pay due to my income, so I qualify for compassion pay. I have the trillium benefit and the drug program covers the rest of the cost. I worry that when my income increases, and when I do get insurance through work, that I will struggle to pay the cost that isn't covered by the trillium benefit and insurance.
I am very concerned about this possible proposal, because Humira has been the only treatment that has helped me since I was first diagnosed in 1995. I have been on it since 2012 and do not want to risk taking anything else instead .
I have gone from Remicade to humira and now to Stelera...hoping I can stay in remission but without the side effects I have experienced with the two former biologics
I have just been approved by Alberta Blue Cross for coverage for HUMIRA. Given that I need to cover 20 percent of the cost, I am wondering whether I will be moved to a biosimilar
I have not needed infusions, my chron's is treated by Mezavant. However, I feel that new patients could be introduced to biosimiliars. If that is not successful they need biologics. Current patients already receiving biological infusions should not be made to switch.
I have yet to go on remicade or the like(docs have been pushing me for years to do so) because of the costs involved . Great medical coverage currently at my work but not sure if i want to stay forever... hence putting off iv meds.
I think the current biologics are too expensive. I was on Humira for 5 months and gained 20 pounds, weight gain was not listed anywhere. Doctors have to start listening to patients
I understand the need to move to cheaper drugs. But as a patient, I have no information about the new drugs...I mentioned it to my GI, and he said I'd be not moving to a different drug.
I was on humira but now I'm on imuran

I've been on and off Purinethol and in remission for the last 20+ years. It was suggested to me to switch to biologics. I figured... if it ain't broke why fix it.
If there is evidence proving that bio similars are as effective then I would be in favour of a cheaper alternative. Both humira and remicade stopped working for me and I'm currently on Stelera. I would hope that my private insurance would not want me to try the biosimilars for Humira or Remicade given that the originals did not work.
Je dois probablement changer de médicament suite au développement d'une tolérance à mon médicament actuel (humira). Je pense qu'un changement de traitement est lourd et stressant.
My daughter has many drug sensitivities. She has reacted poorly and ended up in the hospital as the result. She is doing so well on Simponi and I don't want to mess with something that is finally working.
My doctor was trying to get me on Humira but my insurance company won't cover it and Trillium made me take predisone which really messed me up. Trillium still has me in limbo. Disgusting. If I was a drug addict I could get free drugs every 2 weeks.
Nous sommes maintenant avec entyvio depuis semaine passée, accepté par assureur
Pas facile la maladie de crohn , avec le sterala Mieux, . Merci
Personnellement j'ai deja pris de la prednizone ainsi qu un autre médicament mais je ne consomme plus aucune pilule. J ai été opérée . J ai encore de la diarrhée mais ca va bien.
Si je devais changer pour le biosimilaire de Humira je serai stressé d'avoir des effets secondaires ou d'une baisse d'efficacité
Supports that would be needed would be disability as my child would not be able to work at her job. The current treatment of Entyvio allows to to function on a daily basis and able to go to work so that she can pay her mortgage, her student loans, her car payments, her groceries, etc. If she is forced to go on a 'less expensive' drug treatment she could quite possibly be unable to work. Which means that she would rely on the province to take care of her for the rest of her life. It is more cost effective to ensure the patients are able to get the medication and treatment that puts them into and keeps them in remission. Crohns patients are not guinea pigs for the government to 'try' cheaper medication on they are contributing members of society who are struggling with a debilitating disease that no one should have to deal with. The cost of meds that work for these patients outweighs the perceived costs by the provinces.
This is a crazy idea. Most of us have tried and failed remicade or humira before moving on to entyvio. The only reason u stay on a medication is cause it works for you. I am unclear how ethically we can be asked to switch medications
Why should you be forced to change a medication if the one you are taking (Humira) is working?? My life is hard enough without having to deal with a medication change and the potential negative side effects!
Les assureurs devraient calculer les pertes sur les rechutes potentielles. Les biosimilaires devraient être seulement utilisés sur les nouveaux patients.

we need a canadian made solution to our drug problem so that we are less reliant on the usa for life saving medications
Psycological effects needs to be considered. Efficacy of medication is improved, in my opinion, when the patient believes in the medication he is given.
Good survey. Contact me if more info needed   ian.p.goldman@gmail.com
Would be nice if there was some sort of proper support for this in Kingston. The waiting list just to see a GP is like a year.
Holistic Care is important to us.
I wish for drugs that support immune system instead of ruining it get developed and approved for use for Crohn's and UC faster
Je ne suis pas contre avoir un médicament moins cher, en réalité ce serait benifique mais il faut vraiment s'assurer que les résultats sont identiques car il s'agit de la qualité de vie des patients
Let's fight protest to get better treatment gerd
I feel fortunate my Province has already said they will not enforce switching to biosimilar but if they are ever reconsidering it, maybe undoing it, I would like to know.
My daughter had a very violent reaction all of a sudden to Remicade infusions and, she list 90% of her long, healthy, Beautiful hair. We had to purchase a wig for her to wear and, it was not covered$. At 15 years old, in Grade 10, it was very Devastating to her.   I'm concerned about her care being transferred to adult care. It definitely isn't a fraction as good or top quality to what she has received at Suck Kids in Toronto. I've learned this first hand with her brothers care being switched from Sick Kids to adult doctors and everyday hospitals.
Medications are prohibitively expensive because drug companies can charge whatever they want. If the provinces are to get involved, it should be to keep the costs of medications down in the first place, so that patients can simply have access to the medications that keep them well, regardless of costs.
Crohns should be Canada wide a disability for a handicap sign. I've seen many people park and walk malls with no issues. When we need a Washroom we need a washroom, no reason someone who can walk a mall should get a sign and we can not.