



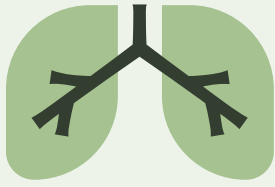
2024 Faces of Lung Cancer Report



**Raising Voices.
Advancing Equity.
Changing Lives.**



**LUNG
CANCER
CANADA**



GIVE A
BREATH
5K



LUNG
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CANADA



Together, we
can make a
difference.

Give a Breath 5K is Canada's premier fundraising event dedicated to supporting the lung cancer community.

Funds raised provide support and education, advance awareness efforts, fuel investigative studies and get much needed resources into the hands of those that need them.

Join us and be a part of
the movement!

giveabreath.ca



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About Lung Cancer Canada

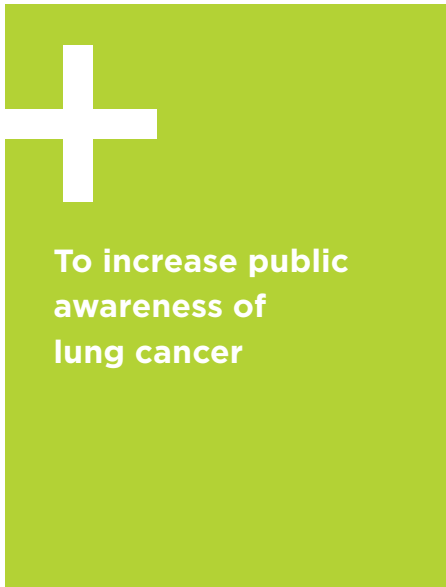


+ Who We Are & How We Help

Lung cancer remains the most commonly diagnosed cancer in Canada, and the most common cause of cancer deaths. It's a disease that not only challenges the physical well-being of those living with lung cancer, but also takes an emotional and financial toll on them, as well as their care partners and loved ones.

In the face of this challenge, Lung Cancer Canada is committed to supporting the lung cancer community, promoting early detection, advancing critical research, eliminating the stigma associated with lung cancer, and advocating for the change needed to ultimately conquer this devastating illness.

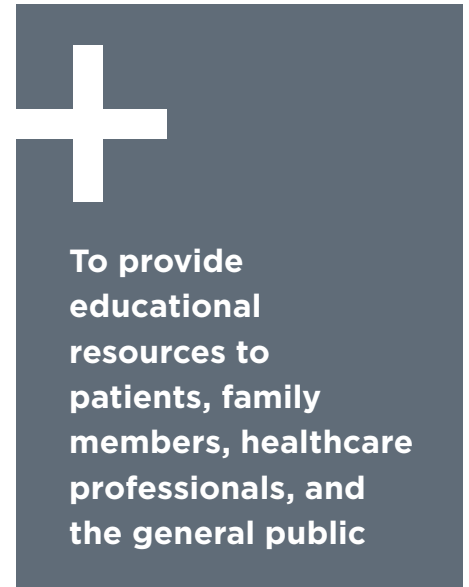
Our Mission:



To increase public awareness of lung cancer



To support and advocate for people living with lung cancer and their families



To provide educational resources to patients, family members, healthcare professionals, and the general public

+ Our Work



Support Programs

We provide a network of resources and services that offer guidance and information, as well as emotional and practical support for persons living with lung cancer and their loved ones.



Education and Awareness

Through educational campaigns and outreach programs about the risk associated with lung cancer and the importance of early detection, we aim to empower communities to make informed decisions about their health.



Research Advancements

We invest in ground-breaking research initiatives that aim to improve the understanding of lung cancer, develop better treatments, and improve health outcomes.



Advocacy

We advocate for policies and initiatives that raise awareness about lung cancer and ensure equitable access to screening and lung cancer treatments.

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Lung Cancer Canada is grateful for the exceptional contributions of its Board of Directors. Their vision and generosity are what drives Lung Cancer Canada's unwavering commitment to the lung cancer community.

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Introduction





+ Setting the Context

Dr. Stephanie Snow
Medical Oncologist, QEII Health Sciences Centre
President, Lung Cancer Canada

As President of Lung Cancer Canada, I've had the privilege of witnessing the remarkable strides forward in lung cancer care, as well as the profound challenges that continue to confront our community. This fight against lung cancer is deeply personal to me. As a medical oncologist specializing in lung cancer, I've walked alongside patients as they navigate the complexities of their diagnosis and treatment. These experiences have not only shaped my career but also fueled my passion for advocacy and change.

One of the most painful realities I've encountered is the stigma that too many lung cancer patients endure. The misconception that lung cancer is exclusively a consequence of smoking persists, even though we know that this disease can affect anyone. Lung cancer does not discriminate by smoking history, and no one should be made to feel that their diagnosis is self-inflicted, regardless of their tobacco use history. This stigma isolates patients, creates unnecessary barriers to care, and delays treatment. Breaking down these harmful misconceptions has been one of my key goals, as every patient deserves compassion, dignity, and timely access to care.

The theme of this year's *Faces of Lung Cancer Report* is equity — a principle that lies at the heart of Lung Cancer Canada's mission. Equity means that every lung cancer patient, regardless of their location, background, or financial situation, should have access to the best possible care. Sadly, this is not yet a reality. There are glaring inequities across Canada, with access to life-saving treatments, clinical trials, and support services varying widely depending on the patient's province or whether they live in a rural or urban area. These disparities are unacceptable and addressing them remains one of Lung Cancer Canada's top priorities.

This year's report shines a light on the voices of patients, caregivers, and clinicians, and it highlights the progress we've made in areas like screening, early detection, and the development of new treatments. But it also underscores the pressing work that remains.

We must continue to push for national standards of care, and ensure equitable access to screening, clinical trials, testing and the treatments which are still unaffordable for too many.

Lung Cancer Canada is working tirelessly to close these gaps through partnerships, research, and advocacy. From educational resources, like *Your Comprehensive Guide to Lung Cancer*, to the patient and caregiver support programs we offer, we are committed to empowering and supporting our community.

At the core of this report are the stories of those who inspire us every day—patients, families, healthcare providers, and advocates. Their resilience and determination drive home the importance of this work and remind us why we must keep pushing forward.

Together, we are working toward a future where lung cancer is no longer stigmatized, where every patient receives the care they need, and where hope is always within reach.

Dr. Stephanie Snow
President, Lung Cancer Canada



+ Looking Ahead

Shem Singh
Executive Director of Lung Cancer Canada

This year's *Faces of Lung Cancer Report* centers on equity—an idea that captures the heart of Lung Cancer Canada's mission. We stand with those who need us most, committed to ensuring that everyone, regardless of where they live or their background, has access to the care, resources, and support they deserve.

While we have made strides in advancing lung cancer care, the powerful stories shared in this report remind us that the challenges remain immense. Lung cancer doesn't discriminate, yet far too often, the systems designed to help do. Barriers to early diagnosis, inequities in access to life-saving treatments, and the uneven distribution of resources leave far too many behind. We are determined to change that.

At Lung Cancer Canada, we are fighting to close these gaps by supporting those impacted by this disease, providing essential resources, building partnerships with those who share our vision, and driving the policy changes needed to improve access for all. But we cannot do this alone.

We need you to join us.

By amplifying the voices of those affected by lung cancer, we can break down the barriers that stand in the way of equitable care. Together, we can create a future where every Canadian facing lung cancer has a fair chance at survival, and a life lived with dignity.

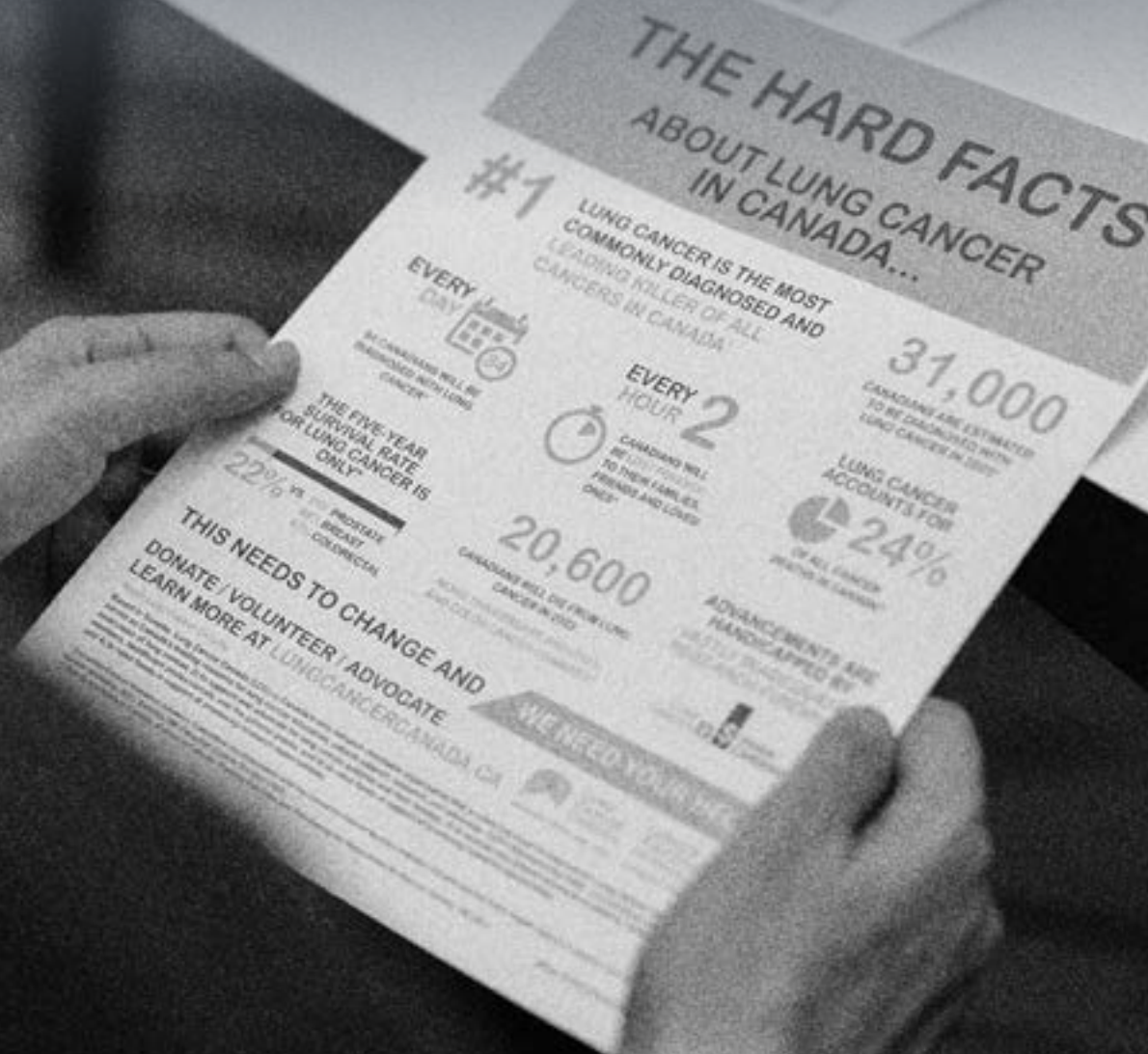
In this spirit of hope and determination, I invite you to explore this year's *Faces of Lung Cancer Report*. These stories are not just stories of struggle. They are stories of resilience, strength, and the incredible power of support and collaboration. They remind us why we do what we do and inspire us to continue pushing for the change that is so desperately needed.

Together, let's ensure that no one faces lung cancer alone.

Shem Singh
Executive Director, Lung Cancer Canada



State of Lung Cancer in Canada





+ Statistics

The 2024 Statistics

Today, lung cancer remains the most commonly diagnosed cancer in Canada, and the most common cause of cancer deaths. It is estimated that 20,700 Canadians will die from lung cancer this year, more than breast, prostate and colon cancer combined.

While advances in research and treatments in the last decade have translated into the survival rate being the highest it has ever been, nearly 70% of lung cancer diagnoses are still made at a late stage, when the disease has already spread through the body and survivorship is low.

Lung cancer
is responsible
for 1 in 4



24%
cancer deaths
among Canadians



70%
are diagnosed
at stage 3 & 4

32,100

Canadians will be
diagnosed in 2024

20,700

Canadians will die in 2024
from lung cancer

1 in 14

Canadians expected to be
diagnosed with lung cancer
in their lifetime



+ Advances and Challenges in Lung Cancer Screening & Early Detection

A CONVERSATION WITH DR. CHRISTIAN FINLEY

Thoracic Surgeon – St. Joseph’s Healthcare
Expert Lead, Canadian Partnership Against Cancer
Clinical Lead, Ontario Lung Cancer Screening Program
Member, Lung Cancer Canada Medical Advisory Committee

Lung cancer remains one of the deadliest cancers worldwide, but advances in screening are beginning to shift the narrative. For Dr. Christian Finley, a thoracic surgeon at St. Joseph’s Healthcare in Hamilton, this fight is deeply personal and professional.

+ Generational Expertise and a Drive to Improve Outcomes

Dr. Finley’s career in thoracic surgery feels like a family tradition. “I’m unique in that my grandfather was a thoracic surgeon, my father is a thoracic surgeon, and now I’m a thoracic surgeon. I’m the only third-generation thoracic surgeon I know of in the world,” he shared. Despite this legacy, his initial interest broad in medical school. Eventually, the complexity and human aspect of thoracic surgery drew him in. “It has a lot of interpersonal aspects—dealing with patients over time, delivering life-changing diagnoses, technical challenges of the operations and guiding them through treatment,” he explained.

His focus on lung cancer screening emerged from his broader perspective on public health. During his Master’s in Public Health at Harvard, Dr. Finley recognized the critical role of early detection in shifting lung cancer survival rates. “Lung cancer screening can improve survival by 20%. It’s a generational opportunity to change the trajectory of lung cancer outcomes,” he emphasized. Early detection, especially through low-dose CT scans, allows for diagnosis at a stage when the disease is still treatable, offering patients a better chance of survival.

+ The Life-Saving Potential of Early Detection

Dr. Finley underscored the vital role early detection plays in lung cancer survival. "Without screening, lung cancer is often found by accident or after symptoms appear, which typically means the disease is already at an advanced stage," he explained. Unfortunately, most lung cancer cases—about 75%—are diagnosed at late stages, when curative treatment is no longer possible, leading to high mortality rates. "In many forms of cancer treatment we celebrate extending life by a few months, but with early-stage lung cancer, surgeons can cure up to 80% of patients," Dr. Finley noted.

Lung cancer screening through low-dose CT scans offers the best chance for early detection, catching the disease before it progresses to an advanced stage. This shift, Dr. Finley believes, is crucial to saving lives. "Pulling people back into early-stage disease, where it's curable, is key to improving outcomes," he said.

+ Addressing the Equity Challenge

While technology has made lung cancer screening more accessible, significant barriers remain for many populations, especially those from lower socio-economic backgrounds. Lung cancer disproportionately affects marginalized communities, and Dr. Finley pointed out the strong correlation between smoking—a leading cause of lung cancer—and socio-economic status. "Smoking is inversely proportional to wealth, or better put, it's linked to social determinants of health," he explained.

In his practice, Dr. Finley sees the impact of these inequities firsthand, particularly in underserved areas where he has worked. Many of his patients lack access to family doctors, face transportation challenges, or have limited health literacy. "In places I have worked, there's no public transit, and many people don't have the time or resources to travel for care" he said. For those working low-wage jobs, taking time off for medical appointments can be impossible.

These barriers are compounded by cultural and systemic challenges, including distrust in the healthcare system. "Among Indigenous populations, there's a long history of racism and marginalization, which leads to distrust and reluctance to seek care," Dr. Finley noted. For recent immigrants, language barriers and unfamiliarity with the healthcare system can delay access to screening and treatment.

The disparities are even more pronounced in rural and remote communities. "People in remote areas may not have access to screening at all or the resources to travel to a center," Dr. Finley explained. This creates a "multiple hit phenomenon," where those at higher risk of lung cancer face compounded obstacles to care, leading to worse survival outcomes. "It's like a 30% decrease in survival due to these stacked odds," he said.

+ A Call for Systemic Solutions

To address these challenges, Dr. Finley advocates for policy changes and better distribution of screening services. One solution is the expansion of "hub-and-spoke" models, where screening centers are more widely distributed, making it easier for patients in remote areas to access services. While mobile units have been suggested, Dr. Finley believes that fixed centers with satellite locations are a more sustainable and effective solution for Canada's geography. "You get a much higher value proposition with fixed sites and hub-and-spoke models," he said.

He also sees potential in technology, particularly the use of artificial intelligence (AI), to help improve diagnostic accuracy in under-resourced areas.

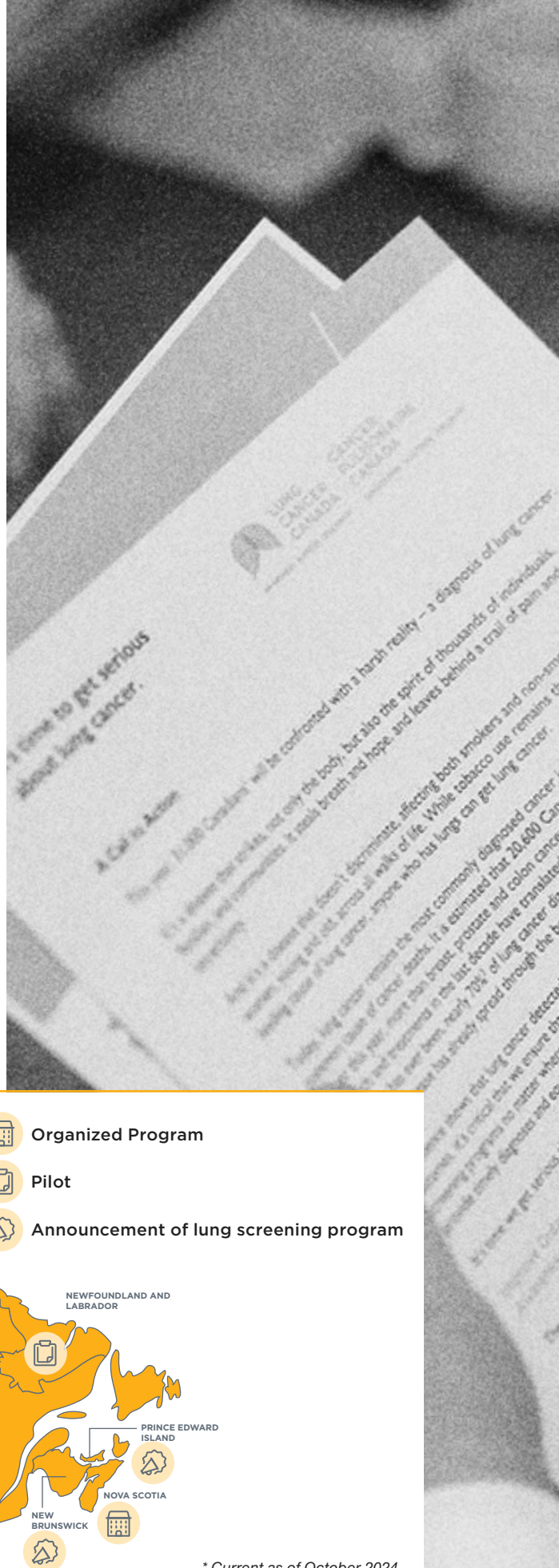
+ Looking Forward: The Generational Opportunity

Dr. Finley remains optimistic about the future of lung cancer screening in Canada. While progress has been slow, with programs like British Columbia and Ontario's expanding and other provinces following suit, he believes that much more can be done to increase participation and ensure equitable access. Public education and outreach are critical to these efforts. "We're constantly bombarding family doctors with information, but it's worth the continued effort to prioritize this" he said. He emphasized the importance of grassroots advocacy and community-based organizations in raising awareness, particularly among underserved populations. "Often people listen to their neighbours and family more than doctors," he remarked.

Dr. Finley calls for greater investment in lung cancer screening, highlighting the importance of equity in healthcare. "We need our fair share of the pie," he said. For Dr. Finley, lung cancer screening is not just a medical issue but a moral imperative. "It's a generational opportunity, and we need to seize it."

+ State of lung cancer screening in Canada

 Planning or Implementing Activities  No Current Lung Screening Activities





+ The Promise of New and Emerging Treatments: Accelerating Access to Advanced Care

A CONVERSATION WITH DR. DAVID STEWART

Medical Oncologist – The Ottawa Hospital
Member, Lung Cancer Canada Medical Advisory Committee

Dr. David Stewart, medical oncologist at The Ottawa Hospital and Professor of Medicine at the University of Ottawa, sheds light on the rapidly evolving treatment landscape in lung cancer, a disease that impacts over 32,000 Canadians each year and accounts for close to 25% of all cancer deaths. Since his career began in the 1970s at MD Anderson Cancer Center in Texas, he has witnessed firsthand the evolution of the field. “We’re seeing treatments today that were science fiction even just a few years ago, and that offers so much new hope to patients who previously had few options,” he explains.

Initially drawn to oncology due to his expertise in pharmacology and the emerging role of chemotherapy, Dr. Stewart’s focus eventually narrowed to lung cancer, a complex disease with high mortality rates. “Patients often present at later stages, complicating treatment. Tackling this challenge has always motivated me,” he states, adding, “The most promising treatment is always the one that hasn’t been discovered yet.”

+ Chemotherapy: The Cornerstone of Treatment, but with Limitations

Chemotherapy has long been the cornerstone of cancer treatment, targeting rapidly dividing cancer cells to prevent their spread. However, its systemic effects can lead to significant side effects such as nausea, fatigue, and hair loss. Despite these drawbacks, chemotherapy remains a critical tool, especially in combination with other therapies, and for more rare types of lung cancer where more targeted options are limited. “While

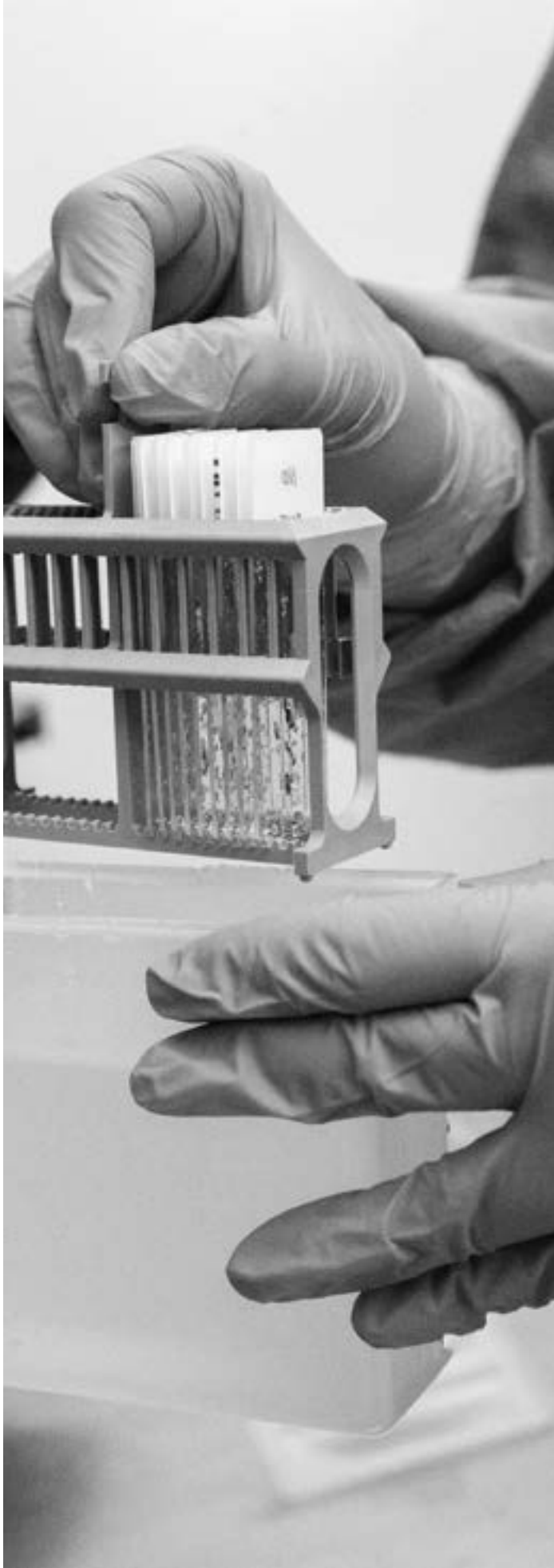
chemotherapy can be effective, its non-selective nature often results in toxicity,” Dr. Stewart notes. As a result, the main focus of cancer research over the last few decades have been to develop new treatment options that are more specific in targeting cancerous cells.

+ Immunotherapy: A Game-Changer in Cancer Care

One of the most exciting advancements in recent years has been immunotherapy, which utilizes the body’s own immune system to fight cancer. Immune checkpoint inhibitors, such as PD-1, PD-L1, and CTLA-4 blockers, have demonstrated remarkable success in improving survival in certain lung cancer patients. However, the body has 13 different immune checkpoints, many of which are not yet targeted by treatment, so not all patients benefit equally, highlighting the need for continued innovation.

+ Targeted Therapies: Precision Medicine on the Rise

Targeted therapies have become a powerful tool, focusing on specific genetic mutations driving cancer growth. Unlike chemotherapy, which indiscriminately attacks all rapidly dividing cells, targeted therapies aim directly at cancerous cells, often with fewer side effects. “These have revolutionized treatment, with dozens emerging in the last decade,” Dr. Stewart explains. However,



challenges remain, particularly with their applicability to various lung cancer types.

Although these targeted therapies are incredibly effective at targeting specific driver mutations in non-small cell lung cancer, these mutations aren't necessarily applicable to other types of lung cancers, such as small-cell and squamous cell lung cancers, which is why standard treatment options in those rarer types remain immunotherapy and chemotherapy. "If we ever do find these driver mutations in other lung cancer types though, then we'd have the potential to have targeted therapy – but right now, we're just not there yet."

Resistance is also a critical hurdle that patient and oncologists face in the effectiveness of these treatments overtime. At first, targeted therapy drugs can suppress the sensitive cancer cells, but resistant clones can emerge overtime. "It's like we wipe out the easier-to-kill part of the cancer, but the tougher part that was hiding in the background takes over". As these resistant cells grow, the cancer comes back, and the original treatment becomes ineffective. The future potential of using AI to design a drug that defines the shape of its target cells and is able to be specifically manufactured for each individual patient is one that Dr. Stewart is looking forward to, but he warns it's still "very much science fiction".

+ Emerging Therapies: New Frontiers

Looking forward, there is incredible research happening in the field of lung cancer, with new technologies in screening, diagnostics, and treatments rapidly advancing the future for Canadians impacted by lung cancer.

One notable development is the potential for an mRNA vaccine, akin to the COVID-19 vaccine, aimed at strengthening the immune response against non-small cell lung cancer. Although still in early stages, success here would mark a significant leap in cancer treatment.

Additionally, antibody-drug conjugates (ADCs) and bispecific T-cell engagers (BiTEs) show promise, binding selectively to cancerous cells while minimizing toxicity. However, Dr. Stewart cautions that these treatments still rely on over-expression of antigens, which may limit their effectiveness.

+ Barriers to Access: Equity and Speed in Treatment Delivery

While there are numerous exciting treatments on the horizon, the issue of accessibility and inequities in diagnostics remains a significant barrier for Canadians. “Amongst the OECD countries, Canada ranks near the bottom in the number of CAT, MRI, and PET scanners, and hospital beds per million population,” he points out. “But that’s actually not the biggest problem – our biggest problem is the shortage of cancer specialists. They are critical for making the initial diagnoses, doing biopsies, ordering surgeries, reading scans, and reading pathology results. Canada ranks 28th out of 32 OECD countries in the number of oncologists per population. These shortages delay the rest of the steps needed to get a patient from the initial diagnosis through settling into treatment, particularly in rural or underserved areas away from major city centers, where patients often present with more advanced disease.”

Once a patient receives a diagnosis, getting access to the latest treatments is another major hurdle. In Canada, the regulatory approval process is slower compared to other OECD countries, leading to delayed access to life-saving drugs. “We have to wait over a year longer than the average wait time for other OECD countries for a new cancer drug to get approval, resulting in significant inequities in care,” he laments. There is also a significant gap in the drugs publicly funded from coast-to-coast.

One potential solution Dr. Stewart suggests is cost-sharing agreements, where governments only pay for treatments that show efficacy. This model would ensure that patients can access cutting-edge therapies more quickly, while also addressing concerns about the high cost of new drugs. Alternatively, countries like the United Kingdom and Germany negotiate the prices of drugs at the same time as they do their health technology assessment, but currently in Canada, this negotiation only happens once there is a formal approval for public funding at the federal and provincial levels, further adding to the lengthy timeline before patients have access to the drug in their hands.



+ Preparing for Success: The Future of Cancer Care

Despite the challenges, Dr. Stewart remains optimistic. “Things have changed explosively in recent years,” he observes, noting that treatments once deemed miraculous are now routine, allowing patients to survive for years rather than months.

Overall, the future of lung cancer treatment looks very bright, with breakthroughs in immunotherapy, targeted therapies, and even new personalized treatment options on the horizon. However, for these advancements to benefit all patients, significant changes are needed in how we deliver care, from speeding up drug approval processes to ensuring equitable access to diagnostics and treatments. As Dr. Stewart eloquently puts it, “The old way of doing things is too expensive—both in lives and in dollars.” The time to act is now, so that all patients can benefit from the incredible strides being made in lung cancer care.



+ Clinical Trials: Opportunities & Challenges

A CONVERSATION WITH DR. ROSALYN JUERGENS

Medical Oncologist – Juravinski Cancer Centre
Lung Cancer Canada Board Member
Co-Chair, Lung Cancer Canada Medical Advisory Committee

Dr. Rosalyn Juergens is a pioneering force in lung cancer research, dedicating her career to advancing clinical trials that push the boundaries of cancer treatment in Canada. Her passion for clinical research was sparked during her medical oncology training when she witnessed firsthand the profound impact that clinical trials could have on patients' lives. "It was clear to me early on that clinical trials were the pathway to real change for people living with cancer," she reflects. This passion led her to pursue a PhD in clinical investigation, giving her the tools to conduct innovative research and transform the landscape of cancer care.

Since then, Dr. Juergens has become a leading figure in clinical oncology, currently heading the Clinical Trials Unit at Hamilton's Juravinski Cancer Centre, where she has been at the forefront of groundbreaking research. Her commitment to equity and accessibility within clinical trials has driven her to expand opportunities for patients, ensuring that no one is left behind in the fight against cancer.

+ The Impact of Clinical Trials: Unlocking New Hope for Patients

For Dr. Juergens, clinical trials are more than just research studies—they are a lifeline for patients. "Clinical trials are about giving people access to treatments that they may never have had the chance to receive

otherwise," she explains. These trials often provide cutting-edge therapies that are not yet available through standard treatments, offering hope to patients who have exhausted other options.

Her experience at Johns Hopkins during the early days of immunotherapy trials is a testament to this belief. Dr. Juergens recalls witnessing the first-in-human trials of PD-1 and PDL-1 inhibitors—breakthrough immunotherapies that revolutionized cancer care. "I saw people whose lives were saved because of those trials," she remembers. One patient with stage IV lung cancer, among the first to respond to immunotherapy, lived for more than a decade after participating in a trial—a powerful reminder of the life-saving potential of this research.

Lung cancer patients, in particular, have benefitted greatly from clinical trials, which have introduced innovative treatments like targeted therapies and immunotherapies that are transforming survival rates and quality of life. Dr. Juergens highlights that without clinical trials, many of these advancements wouldn't be possible. "Every breakthrough in lung cancer treatment—whether it's targeted drugs for genetic mutations or immunotherapies—started in a clinical trial," she emphasizes.



+ Equity in Clinical Trials: Breaking Down Barriers

Despite these successes, Dr. Juergens is acutely aware of the barriers that prevent many patients from accessing clinical trials—barriers that disproportionately affect those from underserved communities. “Lung cancer doesn’t discriminate, but access to treatment often does,” she notes. “Patients from rural areas, those with limited financial resources, and Indigenous populations often face insurmountable challenges in participating in trials, particularly when they are conducted in major urban centers far from home.”

“If you’re living paycheck to paycheck and you have to travel hours to a cancer center, the thought of enrolling in a clinical trial becomes overwhelming,” Dr. Juergens explains. These barriers are compounded for lung cancer patients, who frequently face stigma due to the perceived link between lung cancer and smoking, further discouraging them from seeking out experimental treatments.

To tackle these inequities, Dr. Juergens advocates for decentralizing clinical trials—bringing research to patients, rather than expecting patients to travel to urban hubs. She envisions a future where trials operate on a hub-and-spoke model, allowing patients to participate from local centers while the data and regulatory aspects are handled centrally. The COVID-19 pandemic, she adds, has accelerated this shift, demonstrating that remote trials can be successful and safe. “We’ve shown that trials can happen anywhere, and patients shouldn’t have to choose between treatment and staying close to home.”

+ Transforming Clinical Trials for All Canadians

Looking ahead, Dr. Juergens is optimistic about the future of clinical trials in Canada. National efforts, such as the Canadian Cancer Clinical Trials Network (3CTN), are already working to expand trial access to underserved regions, making it easier for patients across the country to benefit from experimental treatments. However, she believes more can be done to improve participation, including moving toward an “opt-out” model, where patients are automatically considered for trials unless they decline. “Right now, it’s the patient who has to opt-in, but by switching that, we could ensure broader participation and bring more opportunities to the people who need them,” she suggests.

+ Clinical Trials: A Lifeline for Lung Cancer Patients

For lung cancer patients, participation in clinical trials can be the difference between life and death. Many of the most important treatments for lung cancer, including therapies targeting mutations like EGFR and KRAS, were made possible by clinical trials. These advancements are changing the way lung cancer is treated, allowing for more personalized therapies with fewer side effects than traditional chemotherapy.

Yet access remains a challenge, particularly for patients outside of major metropolitan areas. Dr. Juergens is particularly concerned about the disparities in clinical trial participation among those facing financial or geographic



challenges. “It’s the patients who could benefit the most from these cutting-edge treatments who are often the least likely to participate,” she laments.

Part of the solution, Dr. Juergens believes, lies in education and dispelling the myths surrounding clinical trials. “Many people think of clinical trials as being risky, or that they’ll be treated like guinea pigs,” she explains. But the reality is that trials often provide patients with the best possible care, offering access to new treatments alongside additional support and monitoring.

+ A Future of Equity and Innovation

Dr. Juergens remains unwavering in her belief that clinical trials are the key to the future of cancer care. But to fully realize their potential, the barriers to participation must be dismantled. “It’s not just about the science,” she says, “it’s about ensuring that everyone has equal access to these life-saving treatments.”

As she continues to lead the way in lung cancer research, Dr. Juergens is hopeful that through collaboration, innovation, and a commitment to equity, the future of clinical trials will be more accessible and inclusive for all patients—especially those who need it the most.

“Trials are the future,” she asserts. And with her vision for a more equitable system, that future looks brighter for lung cancer patients across Canada.



+ Building Hope for the Future: Recent Advances in Lung Cancer Research

A CONVERSATION WITH DR. STEPHEN LAM AND DR. GEOFFREY LIU

Dr. Stephen Lam
Respirologist – BC Cancer
Member, Lung Cancer Canada Medical Advisory Committee

Dr. Geoffrey Liu
Senior Scientist – Princess Margaret Cancer Centre
Member, Lung Cancer Canada Medical Advisory Committee

Ground-breaking advancements in lung cancer research are offering new hope for patients, with numerous clinical trials and research projects emerging in the coming months. Two leaders in this field, Dr. Stephen Lam at BC Cancer and Dr. Geoffrey Liu at Princess Margaret Cancer Centre, have devoted their careers to advancing lung cancer detection, treatment, and care. “We’re seeing significant changes in how we treat lung cancer, thanks to developments in molecular biology, immunology, imaging, drug development, and artificial intelligence,” says Dr. Lam. Their work is transforming the landscape of lung cancer care, with advances in early detection and targeted therapies offering a brighter future for patients.

+ Early Detection of Lung Cancer: Advances in Screening

Recent advancements in early detection and screening have dramatically improved lung cancer outcomes. Dr. Geoffrey Liu, who leads the early detection research program at Princess Margaret Cancer Centre, focuses on improving cure rates by identifying lung cancer earlier. Initially, screening targeted heavy smokers, but Dr. Liu notes, “Two-thirds of the patients in my hospital today wouldn’t have qualified for screening because they didn’t smoke or didn’t smoke enough. Lifetime never-smoker rates have surged in recent decades.” His team is now exploring new detection methods, including blood and

breath tests, to identify non-smokers and light smokers who are often missed under traditional screening criteria.

Dr. Lam adds that screening programs are expanding to consider environmental risk factors, like air pollution, as smoking rates decline in Canada and other Western nations. “We’re close to incorporating these factors into screening,” he says, emphasizing the need to identify vulnerable populations more effectively. Both Dr. Lam and Dr. Liu highlight the role of AI in screening, with Dr. Lam explaining, “AI is improving how we use CT scans to predict lung cancer risk and assess tumor aggressiveness.” Dr. Liu agrees, noting that AI can streamline the screening process, making it more accessible and efficient for a wider range of people.

+ Advances in Treatment: Precision Medicine and Immunotherapy

Dr. Liu and Dr. Lam are also at the forefront of groundbreaking developments in treatment, including targeted therapies and immunotherapy, which have transformed lung cancer care. Dr. Liu recalls the early days of his career when treatment options were limited. “In the first seven years of my practice, there was only one new lung cancer treatment. Now, new therapies are emerging every few months,” he says, reflecting on the explosion of innovation over the last decade.

Precision medicine, which tailors treatments based on the molecular and genetic profiles of tumors, is one of the most exciting breakthroughs. Dr. Lam describes it as a “quantum leap” in lung cancer care, noting that advancements in molecular biology and immunology are reshaping how the disease is treated. Dr. Liu points to recent updates shared at major conferences, including new treatments for various targetable subtypes like EGFR, VEGF, ALK, and ROS1, which offer fresh hope for Canadian patients across the country.

Immunotherapy has also revolutionized treatment, particularly for non-targetable lung cancers, with survival rates increasing from 1-2% to over 30% for some patients. “Immunotherapy is changing the way we treat lung cancer,” Dr. Lam says. “The outcomes we’re seeing are extraordinary.” Recent data suggests that “newer ways of delivery of such immunotherapies, in the form of bispecific antibodies, may further revolutionize strategies and improve outcomes”, says Dr. Liu.

+ Addressing Disparities and Expanding Access

Despite these advancements, disparities in access to care remain a challenge. Dr. Lam stresses that socioeconomic factors still affect Canadians’ access to early detection and treatment, particularly in underserved communities. Programs in British Columbia and Ontario are working to reach rural populations, Indigenous communities, and lower-income patients, with geospatial mapping helping to identify where patients face barriers to care. “We’re addressing these gaps, but there’s more work to do,” Dr. Lam says.

Dr. Liu is tackling another critical issue: gathering real-world data to support access to new treatments for rare lung cancer subtypes. His national initiative, the Canadian Rare Molecular Alteration Basket-umbrella Real-world Observational Study (CARMA BROS), collects data from patients with rare mutations to support regulatory approval and funding for treatments. “Real-world evidence is crucial in proving the value of therapies for rare mutations,” Dr. Liu explains. “By expanding our networks, we’re able to bridge the gaps and make sure that everyone, regardless of where



they live or their income level, has access to the latest treatments and screening tools.” Such a national network can also identify and highlight inequities in drug access geographically.

+ The Future of Lung Cancer Research: A Message of Hope

Looking ahead, Dr. Liu and Dr. Lam are optimistic about the future of lung cancer care. Precision medicine, immunotherapy, and AI are poised to revolutionize the field even further. Dr. Liu envisions a future where lung cancer is a chronic, manageable condition. “When I started, lung cancer was a death sentence, but now we’re seeing incredible progress,” he says. Dr. Lam shares this hope, especially as early detection methods continue to improve. “The advances we’re seeing will have a significant impact on patient outcomes,” he concludes.

In the face of these challenges, both experts are committed to ensuring that every lung cancer patient has access to the care they need. “There’s so much hope,” Dr. Liu says. “We’ve come a long way, and the future looks even brighter.”



Voices of Hope and Resilience

Stories of Those with Lived Experience





+ Caregiver and Clinician Advocacy: A Collaborative Effort

A CONVERSATION WITH TANYA BOSSY AND DR. KEVIN JAO

Tanya Bossy
Caregiver Advocate

Dr. Kevin Jao
Medical Oncologist - Hôpital du Sacré-Cœur-de-Montréal
Co-Chair, Lung Cancer Canada Medical Advisory Committee

When NHL legend Mike Bossy was diagnosed with stage 4 lung cancer in October 2021, a wave of shock rippled across the hockey world around how the disease not only affects the patient – it alters the lives of everyone connected to them.

For his daughter Tanya, the battle was intensely personal—a whirlwind of hope, grief, and a sudden shift from being his biggest fan to becoming his caregiver. Alongside his oncologist, Dr. Kevin Jao in Montréal, Tanya faced the emotional and physical challenges of caring for her father, a role she never imagined would be thrust upon her. Together, their intertwined journeys as caregiver and clinician reveal the profound impact that lung cancer has on families, caregivers, and the healthcare team, underscoring the importance of advocacy, support, and compassionate care.

+ The Importance of Caregiver and Family Support

From the beginning, the prognosis was clear —stage 4 lung cancer, incurable. However, like many families grappling with such devastating news, they clung to hope as they pursued treatment options. “It was a fast and overwhelming journey,” Tanya reflects, describing the six months from her father’s diagnosis to his passing in April 2022. He first underwent immunotherapy, but when his cancer progressed, chemotherapy followed, bringing harsh side effects and complications. By February 2022, the family made the heart-wrenching decision to stop treatment and focus on comfort care at home. “My dad slowly lost all his capacities, and we had to do so much for him. He wasn’t used to that, and neither were we. It felt like a tsunami,” Tanya recalls.

The rapid shift from being Mike Bossy’s daughter to becoming his caregiver was one of the most emotionally challenging parts of the journey for Tanya. “He went from being the strongest person in our family, a public figure admired by so many, to someone who needed help with everything. I wasn’t prepared for that role reversal. It was heartbreaking to see him lose so much of himself.”

Caregiving, for Tanya, was more than managing medications and coordinating treatments. It was about being present for her father during his most vulnerable moments, watching him become a shell of the man

she had known her entire life. “I was constantly torn between easing his physical pain and dealing with my own emotional pain. It was a lot of anger, guilt, and helplessness. Sometimes, caregiving didn’t feel like love; it felt like pain,” Tanya shares. Despite her love for her father, the overwhelming responsibility of caregiving consumed her, leaving little space to process her own grief or take care of herself.

+ Balancing Self-Care and Caregiving

Finding balance between caring for her father and taking care of herself was one of the greatest challenges Tanya faced. “I went beyond my limits,” she admits. “I was so focused on what my dad needed that I didn’t stop to think about what I needed. And when you don’t respect your limits, it catches up with you.” Tanya’s experience reflects a common struggle among caregivers, who often sacrifice their own well-being out of a sense of guilt and responsibility. Her father, aware of the toll it was taking, urged her to take breaks. Yet, like many caregivers, Tanya found it difficult to step away, haunted by the feeling that if she wasn’t there, she was failing him.

Through the overwhelming demands of caregiving, Tanya found a lifeline in her father’s medical team, particularly Dr. Jao. “Dr. Jao didn’t just focus on my dad’s treatment. He took the time to check in on me and my family. He saw that we were struggling, and that made a world of difference,” Tanya shares. This emotional support from the clinician helped her feel less isolated in her caregiving role.

+ The Role of Clinicians in Supporting the Caregiver

For Dr. Kevin Jao, lung cancer is more than a medical challenge - it’s a human one. His commitment to understanding the emotional and psychological toll that cancer takes on patients and their families is central to his approach to care. After training at Princess Margaret Cancer Centre in Toronto, Dr. Jao was exposed to the profound impact of patient-centered care, where emotional support for both patients and caregivers is an integral part of the treatment journey.

“Caregivers like Tanya play an essential role in patient outcomes,” Dr. Jao explains. “It’s not just about the medical treatment. It’s about the emotional support the patient receives at home—the social, emotional, and psychological care that no medication can replace.” He stresses that family support is often a critical factor in how well patients cope with treatment. “A lot of patients who have a strong support system fare better because they’re not facing this journey alone.”

Dr. Jao also recognizes the heavy burden caregivers carry and the importance of building strong relationships with both patients and their families. He believes in fostering open, honest communication that balances hope with reality. “It’s a delicate balance,” Dr. Jao says. “As clinicians, we need to give families space to ask questions, process the information, and make decisions, even when time is limited. That extra bit of compassion can make a huge difference in their experience.”

+ The Future of Caregiver and Clinician Advocacy

After her father’s passing, Tanya channeled her grief into advocacy, continuing Mike Bossy’s legacy through her work with Lung Cancer Canada. She launched the Mike Bossy Memorial Fund and became an outspoken advocate for lung cancer screening and reducing stigma around the disease. “If my dad had been screened earlier, he might still be here today,” Tanya reflects. “When my dad passed away, the first question people asked was, ‘Did he smoke?’ I could tell them yes or no, but it shouldn’t matter. Whether someone smoked or not, no one deserves cancer. That stigma is powerful, and we need to break it.”



Dr. Jao shares Tanya's passion for advocacy, particularly in addressing the stigma surrounding lung cancer and pushing for better access to early screening. His involvement with Lung Cancer Canada stems from a desire to amplify the voices of lung cancer patients and caregivers. "Advocacy isn't just about treatment. It's about giving patients and their families a voice, recognizing that they are more than just a diagnosis. As physicians, we have a responsibility to help tell their stories and fight for better care," he explains.

Both Tanya and Dr. Jao agree that there's much more to be done in supporting caregivers. "We need to do better, as a healthcare system and as a society," Dr. Jao asserts. "Caregivers are essential to a patient's journey, and we need to provide them with the tools and support they need to carry that weight. It's not just about the patient's health—it's about the family's health too."

+ A Shared Mission for Change

In the face of unimaginable loss, both Tanya and Dr. Jao have emerged as advocates for change in how we approach lung cancer care and support for caregivers. Tanya's journey as a caregiver has inspired her to speak out, ensuring that no one else has to face the same stigma or lack of resources her father did. Dr. Jao continues to fight for a healthcare system that sees the patient as a whole person, surrounded by loved ones who also need care and support.

Their shared story is a reminder that cancer is not a solitary battle. It's a journey shared by patients, caregivers, and clinicians—a collaborative effort that requires compassion, resilience, and a deep commitment to advocacy. Together, Tanya and Dr. Jao are working to create a future where no one has to walk this path alone.





+ The Power of Support

A CONVERSATION WITH BEV MOIR AND RON FOREMAN

Bev Moir
Patient Advocate

Ron Foreman
Caregiver Advocate

Bev Moir and Ron Foreman's journey together began over 20 years ago, united by a shared love for staying active—one of their first adventures was running the Washington Marathon.

Since then, they've built a remarkable life, balancing careers and personal achievements. Bev transitioned from a long career in healthcare to spend 27 years in wealth management, while Ron owned a successful web development business before they both retired not long ago. However, their lives took a sudden and unexpected turn in 2019 when Bev was diagnosed with lung cancer after a persistent cold following a European cruise.

The stage 4 lung cancer diagnosis was shocking for Bev, a never-smoker who had always considered herself in excellent health. "They weren't looking for lung cancer in me," Bev recalls, explaining how her symptoms of a cough, sore throat, and gradual weight loss were initially brushed aside as lingering effects of a cold. "I was healthy, always fit, and expected to live to 100. When they found the metastatic tumors in my lungs, it was disbelief all around."

Ron, who had experienced cancer himself, had a more pragmatic outlook on life's unpredictability. "By the time you reach a certain age, you understand that bad things can happen," he reflects. "But I was still shocked that Bev, a non-smoker, would be diagnosed with lung cancer."

Fortunately, further biomarker testing revealed that Bev had the EGFR Exon 19 mutation—a treatable, targetable mutation. Since February 2020, her treatment has been a targeted therapy which has been remarkably successful in managing her disease for over 5 years with minimal side effects. Thanks to lifestyle adjustments, Bev continues to enjoy an excellent quality of life, staying active by playing tennis, golfing, power walking, practicing yoga, and even completing the Ottawa half-marathon in May 2024.

+ The Power of Support

Throughout it all, Ron has been Bev's unwavering support. Their relationship has only grown stronger as they've faced this challenge together. "We've always been a team," Ron says, noting how their partnership deepened as they navigated her treatment. Whether attending medical appointments or taking on daily tasks, Ron has embraced his caregiving role with love and dedication. "We tackle everything together. Facing this has made us stronger."

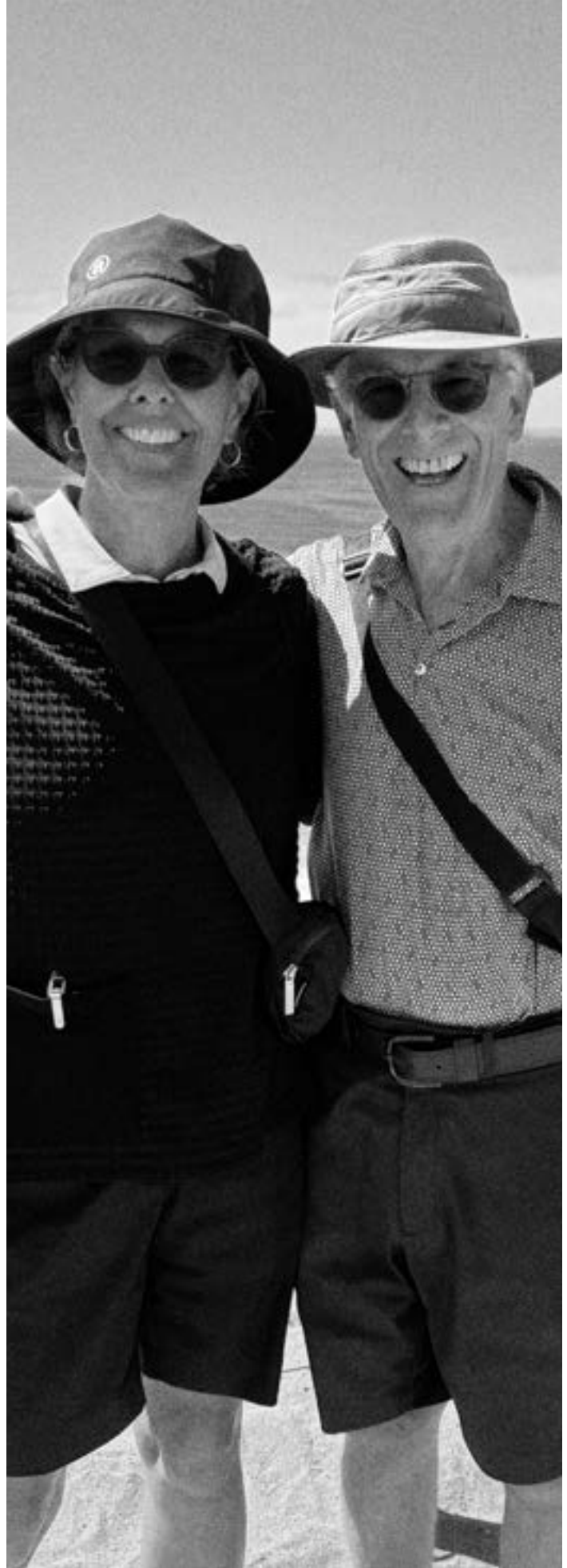
For Bev, Ron's support has been invaluable. "I never feel like I'm going through this alone," she shares. "Knowing Ron is with me every step of the way makes all the difference." Ron, however, remains humble about his role. "I'm not dealing with oxygen tanks or medical equipment. I make sure her computer works so she can continue advocating," he says with a smile, reflecting on the technical support he provides for her lung cancer advocacy work.

Spending precious time with their two young granddaughters has also become especially meaningful for Bev and Ron. "It's such a gift for us, and moments like these remind us of what really matters," Ron shares, underscoring how important family has become in this chapter of their lives.

Beyond their relationship, both Bev and Ron have found immense value in external support systems. Bev stays connected through her tennis, golf, and Toronto Power Walking groups. For Ron, joining men's groups has provided a source of camaraderie and perspective. Online lung cancer support groups have also offered a safe space for them to connect with others. "Having a strong support network is essential," Bev emphasizes. "Opening up to others, finding people who understand, and learning from their experiences can provide hope when you need it most."

+ Equity in Lung Cancer: Access and Awareness

For Bev and Ron, their advocacy journey has also exposed them to the significant inequities in lung cancer diagnosis and treatment—disparities that motivate





them to speak out even more. Bev, a former healthcare professional and wealth advisor, found herself confronting a deeply entrenched stigma: lung cancer is often associated only with smoking, overshadowing other causes. “There’s this assumption that if you have lung cancer, it’s because you smoked,” Bev explains. “But that’s not the case for many of us, and it’s important that we break through that stigma.”

This stigma delays diagnoses for non-smokers and leads to underfunding for research and treatment options. Bev and Ron stress the need for greater public awareness and equity in healthcare access, advocating for more comprehensive screening programs that don’t focus solely on those with a smoking history. “Early detection is critical, but the current screening guidelines often leave out people like me, or those with a family history of lung cancer,” Bev says. “Everyone should have access to early diagnosis, regardless of their smoking history.”

The couple also highlights the barriers to accessing advanced treatments like the one Bev is on. While she has benefited from targeted therapy, many lung cancer patients face obstacles—whether geographic, financial, or related to healthcare policy—that prevent them from receiving the care they need. “It’s not just about the drugs being available,” Ron adds. “It’s about making sure patients can actually get those treatments, no matter where they live or what their background is.”

Through their advocacy, Bev and Ron are determined to push for changes that will ensure lung cancer patients across the spectrum have equal access to care, testing, and treatments.

+ The “Gift” of Cancer and Advocacy

When Bev first shared her diagnosis with colleagues, one of her long-time clients remarked, “You’ll come to see cancer as a gift.” Initially, she dismissed the comment, but now, she reflects on it differently. “It truly has been a gift in many ways. It’s deepened my relationship with Ron, my family, and even old friends I’ve reconnected with. Time is precious, and I’ve realized the importance of cherishing every moment.”

Since her diagnosis, Bev has embraced her voice as a passionate lung cancer advocate. Through her involvement with Lung Cancer Canada, Right2Survive, and her participation in global conferences, Bev is determined to raise awareness and fight the stigma associated with lung cancer. “I feel a responsibility to make a difference—whether it’s improving patient quality of life, increasing public awareness, or advocating for funding,” Bev says. “It was initially hard to speak out, but now my goal is to make as much of an impact as I can, for as long as I’m able.”

Bev and Ron’s advocacy doesn’t stop there. Together, they host their annual **“Crush It with Bev”** fundraiser, supporting Sunnybrook Hospital in Toronto. They also co-host the **Give A Breath 5K** in Toronto with Lung Cancer Canada.

“If we had to sum up our journey in one word, it would be *‘optimism,’*” they say. “We have much life left to live, and we’re going to live it, side by side, making a meaningful difference for lung cancer patients and their loved ones.”



+ The Transformative Power of Precision Medicine

Katie Hulan
Patient Advocate

In February 2021, at just 33 years old, Katie Hulan never expected to face a lung cancer diagnosis. “I had always tried to stay active, eat well, and keep busy with my loved ones and a fulfilling career in marketing. Cancer wasn’t even on my radar.” But what started as a mild cough gradually worsened over several months, and despite multiple doctor visits, her condition was repeatedly dismissed as asthma or allergies.

It wasn’t until nearly five months after her first visit that the true cause was revealed: a tumor in her right lung with four smaller spots that had spread to her brain, and three on her liver. The diagnosis: stage IV lung cancer. “It was such a shock,” she recalls. “I just felt this deep sadness and didn’t even know what to do next.” Yet, even in the darkest moments, Katie found the strength to persevere, transforming her battle with cancer into an inspiring journey.

After her diagnosis, Katie barely had time to process her reality as her medical team in Toronto quickly initiated palliative radiation to manage symptoms and prepare for further treatment. With the tumor pressing against her airways, there was no time to waste. But amid the chaos, it was precision medicine that truly changed the course of her treatment and her outlook on life.

+ A New Path Forward

Katie’s introduction to biomarker testing and precision medicine—treatments tailored to a patient’s genetic makeup and specific disease characteristics—was a turning point. Her oncologist, Dr. Natasha Leighl at Princess Margaret Cancer Centre, discovered that Katie’s tumor was driven by an ALK-positive mutation. This made her eligible for targeted therapy, a treatment that targets specific mutated proteins or genes in cancer cells. Unlike traditional chemotherapy, which attacks the entire body, targeted therapy is more precise and often comes with fewer side effects.



“When I heard ‘stage IV’ in the hospital room, I thought it meant I had very little time left,” Katie explains. “But after Dr. Leighl found the ALK mutation and told me about the targeted therapy, it completely shifted my mindset. She believed I could live many years on this pill instead of just months. That hope was transformative for me—I could actually start imagining a future.”

The impact of precision medicine extended far beyond just prolonging Katie’s life - it also drastically improved her quality of life. Unlike chemotherapy, which is often accompanied by debilitating side effects, Katie’s targeted therapy allowed her to continue living much as she had before. For over three years, she thrived on treatment although finding the right dosage to manage side effects was a challenge. In the summer of 2024, she transitioned to a new treatment, which further boosted her energy levels. This newfound stability gave Katie the courage to make bold moves in her life, including relocating from Toronto to Victoria, BC, just eight months after her diagnosis.

+ Living Fully, Outside the Hospital

For Katie, one of the greatest gifts of precision medicine has been the ability to maintain her independence and continue living life on her own terms. “It gave me so much more confidence because my life has felt so close to normal. I’ve been able to work, socialize, and travel without constant hospital visits. I never imagined that would be possible with a stage IV diagnosis.” Katie is even planning a trip to Italy, relishing her ability to live fully again.

+ The Equity Question and the Power of Advocacy

Despite her success with targeted therapy, Katie is keenly aware that not all patients have the same access to these treatments. “My biggest hope is that we continue advancing this technology, but also ensure it’s equitably funded and accessible for all Canadians, no matter where they live,” she says. Access to new treatments varies widely between provinces, leaving many lung cancer patients without the care they need. Katie hopes to raise awareness about these inequities through advocacy.

Inspired by her own journey, Katie has become a passionate advocate for lung cancer awareness and precision medicine. As a member of the Right2Survive coalition, she is determined to change the narrative around lung cancer. “A lot of the progress in the ALK-positive community in Canada has been led by patients, and I want to do my part. More young, non-smokers like me are being diagnosed with lung cancer, and I feel compelled to speak out and help break the stigma.”

+ Gratitude and Hope for the Future

Reflecting on her journey, Katie feels one overwhelming emotion: gratitude. “It’s wild that I’m here—not just surviving, but thriving. I hope that everyone gets the chance to experience full health, and I know the incredible research in new therapies is why I’m here today. Access to medicine isn’t just about the person—it’s for the whole community around them.”

Katie’s journey is a powerful reminder of the life-changing impact of precision medicine, and her advocacy work is helping to ensure that more patients can benefit from these advancements.



Annual Report on Access to Lung Cancer Treatments Across Canada

+ Access to Treatment

The following tables provide a snapshot of the current availability of lung cancer treatments across Canada*, illustrating how therapies move through the system—from Health Canada approval to provincial coverage.

The data reveals the lengthy process many treatments endure before becoming accessible to those in need. While Health Canada approvals often follow those of the Food and Drug Administration (FDA) in the U.S., securing provincial coverage—which is vital for ensuring patient access—can take significantly longer. This lag creates disparities, with some provinces offering newer, life-saving treatments much sooner than others.

These tables highlight the urgent need to shorten these timeframes and ensure that innovative lung cancer therapies are made available equitably across Canada. Timely access to treatment can be a matter of life or death, and every Canadian, regardless of location, deserves the best possible care. The data reinforces the necessity for ongoing advocacy to accelerate drug approvals and achieve consistent coverage nationwide, ensuring that no one is left behind.

**This includes treatments that have undergone the process for public funding within the last 5 years (2019 and later),*



Table 1 — Status of Canada Drug Agency (CDA) Drug Recommendations

(Within the Last 5 Years)

DRUG Generic Name (Brand Name)	INDICATION	FDA APPROVAL DATE	HEALTH CANADA APPROVAL DATE	CDA STATUS	PHASE DATA USED
alelectinib (Alecensa®) - adjuvant ALK +	As adjuvant treatment following tumour resection in adult patients with Stage IB - IIIA ALK-positive non-small cell lung cancer.	April 18, 2024	June 27, 2024	Currently Under Review	3
amivantamab (Rybrent®)	For the treatment of adult patients with locally advanced or metastatic NSCLC with EGFR Exon 20 insertion mutations whose disease has progressed on, or after platinum-based chemotherapy.	May 21, 2021	March 31, 2022	Final Recommendation March 1, 2023: Reimburse with conditions	1
amivantamab (Rybrent®) w/ Chemo +	In combination with carboplatin and pemetrexed for the first-line treatment of adult patients with locally advanced or metastatic non-small cell lung cancer with EGFR exon 20 insertion mutations.	March 1, 2024	June 28, 2024	Currently Under Review	3
atezolizumab (Tecentriq®) - SCLC	For the first-line treatment of patients with extensive stage small cell lung cancer (ES-SCLC) in combination with a platinum-based chemotherapy and etoposide.	March 18, 2019	August 9, 2019	Final Recommendation September 30, 2022: Reimburse with conditions	3
atezolizumab (Tecentriq®) - Adjuvant	For adjuvant treatment following resection and platinum-based chemotherapy for patients with stage II to IIIA NSCLC whose tumours have PD-L1 expression on ≥ 50% of tumour cells.	October 15, 2021	January 14, 2022	Final Recommendation September 30, 2022: Reimburse with conditions	3
Atezolizumab & Bevacizumab (Tecentriq® & Avastin®)	For the treatment of metastatic EGFR and/or ALK positive non-squamous non-small cell lung cancer in patients who have progressed on treatment with targeted therapies.	December 6, 2018	May 24, 2019	Final Recommendation July 3, 2020: Not Recommended	3
bevacizumab (Mvasi®)	For treatment of patients with unresectable advanced, metastatic or recurrent non-squamous non-small cell lung cancer, in combination with carboplatin/paclitaxel chemotherapy regimen.	September 14, 2017	April 30, 2018	Final Recommendation: Final Biosimilar Dossier Issued January 14, 2019	1 + 3
bevacizumab (Zirabev®)	For the treatment of patients with unresectable advanced, metastatic or recurrent non-squamous non-small cell lung cancer, in combination with carboplatin/paclitaxel chemotherapy regimen.	June 27, 2019	June 14, 2019	March 28, 2019: File closed, Review status: Cancelled	3
cemiplimab (Libtayo®)	As monotherapy for first-line treatment of locally advanced NSCLC expressing PD-L1 (Tumour Proportion Score [TPS] ≥ 50%) with no EGFR, ALK, or ROS1 aberrations.	October 13, 2021	June 2, 2022	Final Recommendation June 2, 2022: Reimburse with conditions	3

+ New for 2024
Current as of October 1, 2024

DRUG Generic Name (Brand Name)	INDICATION	FDA APPROVAL DATE	HEALTH CANADA APPROVAL DATE	CADTH STATUS	PHASE DATA USED
cemiplimab (Libtayo®) w/ chemo +	In combination with platinum-based chemotherapy for the first line treatment of adult patients with NSCLC whose tumours have no EGFR, ALK or ROS1 aberrations and is: locally advanced where patients are not candidates for surgical resection or definitive chemoradiation, or metastatic NSCLC.	November 8, 2022	April 27, 2023	Final Recommendation May 2, 2024: Reimburse with conditions	3
crizotinib (Xalkori®) ROS1	As a single agent as first-line treatment for patients with ROS1 positive advanced NSCLC.	March 11, 2016	August 28, 2017	Final Recommendation May 23, 2019: Recommended pending cost-effectiveness and feasibility of adoption (budget impact)	1 + 2
dabrafenib (Tafinlar®) & trametinib (Mekinist®)	For the treatment of patients with metastatic non-small cell lung cancer (NSCLC) with a BRAF V600 mutation and who have not received any prior anti-cancer therapy for metastatic disease.	June 22, 2017	May 18, 2018	Final Recommendation May 28, 2021: Reimburse with conditions	2
Datopotamab deruxtecan "Dato-DXd" +	Antibody Drug Conjugate for patients with locally advanced or metastatic NSCLC treated with at least one prior line of therapy.	Currently under review	Currently under review	Currently Under Review	3
durvalumab (Imfinzi®) Stage III unresectable NSCLC	For the treatment of patients with locally advanced, unresectable Stage III NSCLC whose disease has not progressed following platinum-based chemoradiation therapy.	February 16, 2018	May 4, 2018	Final Recommendation May 3, 2019: Reimburse with conditions	3
durvalumab (Imfinzi®) ES- SCLC	First-line treatment of adult patients with extensive-stage small cell lung cancer (ES-SCLC) in combination with etoposide and either carboplatin or cisplatin.	March 30, 2020	September 21, 2020	Final Recommendation July 27, 2021: Reimburse with conditions	3
durvalumab (Imfinzi®) LS- SCLC +	Durvalumab for limited-stage small cell lung cancer whose disease has not progressed following platinum-based chemoradiotherapy.	Currently under review	Currently Under Review	Currently Under Review	3
durvalumab (Imfinzi®) - periadjuvant +	In combination with chemotherapy as neoadjuvant treatment, followed by durvalumab as monotherapy after surgery, for patients with resectable NSCLC and no known EGFR or ALK mutations.	August 15, 2024	Currently Under Review	Currently Under Review	3
durvalumab & tremelimumab (Imfinzi & Imjudo®) +	Durvalumab in combination with tremelimumab and platinum-based chemotherapy is indicated for the first-line treatment of patients with metastatic NSCLC with no sensitizing EGFR or ALK mutations.	November 10, 2022	Currently under review	Currently Under Review	3
entrectinib (Rozlytrek®) - ROS1	For the first-line treatment of adult patients with ROS1-positive locally advanced or metastatic non-small cell lung cancer.	August 15, 2019	May 6, 2020	Final Recommendation January 27, 2021: Reimburse with conditions	1 + 2
entrectinib (Rozlytrek®) - NTRK	For the treatment of adult patients with unresectable locally advanced or metastatic extracranial solid tumours, including brain metastases, that have a NTRK gene fusion without a known acquired resistance mutation, and with no satisfactory treatment options.	August 15, 2019	February 10, 2020	Final Recommendation November 21, 2022: Reimburse with conditions	1 + 2

+ New for 2024
Current as of October 1, 2024

DRUG Generic Name (Brand Name)	INDICATION	FDA APPROVAL DATE	HEALTH CANADA APPROVAL DATE	CADTH STATUS	PHASE DATA USED
larotrectinib (Vitrakvi®)	For the treatment of adult and pediatric patients with solid tumours that have a NTRK gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity, and have no satisfactory treatment options.	November 26, 2018	July 10, 2019	Final Recommendation September 13, 2021: Reimburse with conditions	1 + 2
lorlatinib (Lorbrena®) 1st line	For the first-line treatment of adult patients with ALK-positive locally advanced (not amenable to curative therapy) or metastatic NSCLC.	March 3, 2021	June 7, 2021	Final recommendation: March 17, 2022: Reimburse with conditions	3
lorlatinib (Lorbrena®) 2nd line	For the treatment of adult patients with ALK positive metastatic NSCLC who have progressed on crizotinib and at least one other ALK inhibitor, or patients who have progressed on ceritinib or alectinib.	November 2, 2018	February 22, 2019	Final Recommendation January 30, 2020: Do not reimburse	2
lurbinectedin (Zepzelca®)	Treatment of adult patients with Stage III or metastatic small cell lung cancer (SCLC) who have progressed on or after platinum-containing therapy.	June 15, 2020	September 29, 2021	Final Recommendation December 19, 2022: Do not reimburse	2
nivolumab (Opdivo®)	For neoadjuvant treatment of adult patients with resectable NSCLC (tumours ≥4cm or node positive) when used in combination with platinum-doublet chemotherapy.	March 4, 2022	August 23, 2022	Final Recommendation April 18, 2023: Reimburse with conditions	3
Nivolumab- Ipilimumab (Opdivo - Yervoy®)	Nivolumab, in combination with ipilimumab and 2 cycles of platinum-based chemotherapy for the first-line treatment of patients with metastatic or recurrent NSCLC with no EGFR or ALK genomic tumor aberrations.	May 26, 2020	August 6, 2020	Final Recommendation March 4, 2021: Reimburse with conditions	3
nivolumab- ipilimumab (Opdivo-Yervoy®) - MPM	OPDIVO, in combination with ipilimumab, is indicated for the treatment of adult patients with unresectable malignant pleural mesothelioma (MPM) who have not received prior systemic therapy.	October 2, 2020	June 2, 2021	Final Recommendation August 4, 2021: Reimburse with conditions	3
nivolumab (Opdivo®) - periadjuvant +	Neoadjuvant nivo in combination with chemotherapy followed by adjuvant nivolumab for patients with resectable stage II-IIIb NSCLC.	Currently under review	Currently Under Review	Currently Under Review	3
osimertinib (Tagrisso®) - 1st line	For the first-line treatment of patients with locally advanced or metastatic NSCLC whose tumours have EGFR exon 19 deletion or L858R mutations.	April 18, 2018	July 10, 2018	Final Recommendation January 4, 2019: Reimburse with conditions	3
osimertinib (Tagrisso®) - adjuvant	Osimertinib is indicated as adjuvant therapy after tumour resection in patients with stage IB-IIIa NSCLC whose tumours have EGFR exon 19 deletions or exon 21 (L858R) substitution mutations.	December 18, 2020	January 3, 2021	Final Recommendation January 10, 2022: Reimburse with conditions	3
osimertinib (Tagrisso®) - stage 3 unresectable +	For unresectable stage III EGFR-mutant NSCLC following chemoradiotherapy.	Currently under review	Currently Under Review	Currently Under Review	3

+ New for 2024
Current as of October 1, 2024

DRUG Generic Name (Brand Name)	INDICATION	FDA APPROVAL DATE	HEALTH CANADA APPROVAL DATE	CADTH STATUS	PHASE DATA USED
osimertinib (Tagrisso®) w/ chemo +	In combination with pemetrexed and platinum-based chemotherapy for the first-line treatment of patients with locally advanced or metastatic NSCLC whose tumours have EGFR exon 19 deletions or exon 21 (L858R) substitution mutations.	February 16, 2024	July 12, 2024	Currently Under Review	3
pembrolizumab (Keytruda®) - Non-squamous NSCLC	In combination with pemetrexed and platinum chemotherapy, for the treatment of metastatic non-squamous NSCLC, in adults with no EGFR or ALK genomic tumor aberrations, and no prior systemic chemotherapy treatment for metastatic NSCLC.	August 20, 2018	March 13, 2019	Final Recommendation May 31, 2019: Reimburse with conditions	3
pembrolizumab (Keytruda®) - Squamous NSCLC	For the treatment of patients with metastatic squamous NSCLC in combination with carboplatin and either paclitaxel or nab-paclitaxel, in adults with no prior systemic chemotherapy treatment for metastatic NSCLC.	November 2, 2018	July 4, 2019	Final Recommendation January 3, 2020: Reimburse with conditions	3
pembrolizumab (Keytruda®) - adjuvant Stage 1-3A +	As monotherapy for the adjuvant treatment of adult patients with Stage IB, II, or IIIA NSCLC who have undergone complete resection and platinum-based chemotherapy.	January 27, 2023	Currently Under Review	Currently Under Review	3
pembrolizumab (Keytruda®) - MPM +	For advanced malignant pleural mesothelioma.	Currently under review	Currently Under Review	Currently Under Review	2 + 3
pembrolizumab (Keytruda®) - peri-adjuvant +	For treatment of resectable stage II, IIIA, or IIIB NSCLC in combination with platinum containing chemotherapy as neoadjuvant treatment, and then continued as a single agent as adjuvant treatment.	October 16, 2023	Currently Under Review	Currently Under Review	3
pralsetinib (Gavreto®)	For the treatment of adult patients with RET fusion-positive locally advanced unresectable or metastatic NSCLC	September 4, 2020	July 21, 2021	Final Recommendation September 29, 2022: Reimburse with conditions	1 + 2
repotrectinib (Augtyro®) +	Locally advanced or metastatic ROS 1-positive NSCLC.	November 15, 2023	Currently under review	Currently Under Review	1 + 2
selpercatinib (Retevmo®)	Indicated as monotherapy for the treatment of metastatic RET fusion-positive NSCLC in adult patients.	May 8, 2020	June 15, 2021	Final Recommendation May 16, 2022: Reimburse with conditions	1 + 2
sotorasib (Lumakras®) +	For the treatment of adult patients with KRAS G12C-mutated locally advanced (not amenable to curative therapy) or metastatic NSCLC who have received at least one prior systemic therapy.	May 28, 2021	September 10, 2021	Final Recommendation February 29, 2024: Do not reimburse	2 + 3
tarlatamab (Imdelltra®) +	For the treatment of adult patients with extensive stage small cell lung cancer with disease progression on or after at least two prior lines of therapy including platinum-based chemotherapy.	May 16, 2024	Currently under review	Currently Under Review	2
tepotinib (Tepmetko®)	For treatment of adult patients with locally advanced unresectable or metastatic NSCLC harbouring MET exon 14 skipping alterations.	February 3, 2021	May 27, 2021	Final Recommendation August 24, 2022: Not Recommended	2

+ New for 2024
Current as of October 1, 2024

Table 2 — Date of Provincial Drug Coverage

Drug Name	BC	AB	SK	MB	ON	QC	NS	NB	NL	PEI	NIHB
alectinib - 1 st and 2 nd line	May 1, 2019	Mar 1, 2019	Feb 11, 2019	May 31, 2019	Apr 17, 2019	Feb 1, 2019	Oct 1, 2019	May 16, 2019	Oct 8, 2019	Apr 1, 2022	Feb 19, 2019
amivantamab	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
atezolizumab adjuvant	Sept 1, 2023	Jun 5, 2023	Jun 1, 2023	Jun 6, 2023	Jul 5, 2023	Apr 13, 2023	Jul 27, 2023	Jul 13, 2023	Jul 4, 2023	Jun 13, 2024	Not Funded
atezolizumab SCLC	Jun 1, 2023	Oct 20, 2022	Mar 1, 2023	Mar 1, 2023	Mar 10, 2023	Apr 13, 2022	Jul 27, 2023	Apr 19, 2023	Oct 1, 2024	Jun 13, 2024	Not Funded
atezolizumab (2 nd line NSCLC)	Nov 1, 2019	Oct 7, 2019	Feb 11, 2019	Feb 13, 2019	Dec 6, 2019	Feb 1, 2019	Oct 1, 2020	Oct 30, 2019	Not Funded	Dec 12, 2022	Not Funded
brigatinib - 1 st line ALK-positive	Jun 1, 2022	Feb 18, 2022	Mar 1, 2022	Jun 1, 2022	Feb 10, 2022	Feb 2, 2022	Jul 1, 2022	Apr 29, 2022	Oct 17, 2022	Sept 26, 2022	Feb 18, 2022
cemiplimab (PD-L1 ≥ 50%)	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
cemiplimab (any PD-L1)	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
crizotinib (ROS 1)	Jul 1, 2020	Dec 15, 2020	Jul 1, 2023	Jan 21, 2021	Dec 4, 2020	Apr 23, 2020	Jan 1, 2021	Jul 10, 2020	May 1, 2020	Jan 23, 2023	Jul 9, 2021
dabrafenib & trametinib BRAF V600	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
durvalumab Stage III NSCLC unresectable	Feb 1, 2020	Apr 10, 2020	Jan 1, 2020	Dec 11, 2019	Jan 22, 2020	Oct 2, 2019	Jan 28, 2020	Mar 20, 2020	May 14, 2020	Sept 1, 2020	Not Funded
durvalumab 1 st line ES-SCLC	Oct 1, 2022	Jun 15, 2022	Jul 6, 2022	Jul 20, 2022	Jul 22, 2022	Jul 6, 2022	Jul 20, 2022	Aug 3, 2022	Oct 1, 2022	Apr 3, 2023	Not Funded
entrectinib - ROS1	Apr 1, 2022	Jan 21, 2022	Nov 1, 2021	Nov 25, 2021	Dec 23, 2021	Aug 18, 2021	Nov 30, 2021	Oct 14, 2021	May 24, 2022	Dec 28, 2022	Oct 27, 2021
entrectinib - NTRK	Sep 1, 2023	Not Funded	May 1, 2023	Aug 24, 2023	May 16, 2023	Not Funded	Oct 1, 2023	Jun 26, 2023	Oct 1, 2023	Jun 4, 2024	May 19, 2023

Drug Name	BC	AB	SK	MB	ON	QC	NS	NB	NL	PEI	NIHB
larotrectinib	Sep 1, 2023	Feb 16, 2024	Dec 1, 2022	Apr 1, 2023	Feb 24, 2023	Not Funded	Jul 1, 2023	May 23, 2023	Aug 30, 2023	Jan 22, 2024	Jan 23, 2023
lorlatinib 1 st line	May 1, 2024	Aug 1, 2023	Aug 1, 2023	Dec 21, 2023	Jul 17, 2023	Jul 6, 2023	Oct 1, 2023	Sep 28, 2023	Jan 4, 2024	Nov 27, 2023	Sept 1, 2023
lurbinectedin	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
nivolumab neo-adjuvant NSCLC	Feb 1, 2024	Aug 14, 2023	Oct 1, 2023	Oct 5, 2023	Sept 13, 2023	Sept 27, 2023	Oct 1, 2023	Sept 29, 2023	Not Funded	Mar 25, 2024	Not Funded
nivolumab MPM	May 1, 2022	Apr 1, 2022	May 1, 2022	Apr 1, 2022	Jun 7, 2022	Mar 2, 2022	Aug 1, 2022	Jun 23, 2022	Jun 1, 2022	Dec 1, 2022	Not Funded
nivolumab - ipilimumab (Opdivo - Yervoy®) 1L NSCLC	May 1, 2022	Apr 1, 2022	May 1, 2022	Apr 1, 2022	Jun 15, 2022	Nov 9, 2022	Aug 1, 2022	Jun 23, 2022	Jun 5, 2022	Dec 1, 2022	Not Funded
osimertinib - 1 st line EGFR	Jan 1, 2020	Apr 10, 2020	Mar 1, 2020	Apr 2, 2020	Jan 10, 2020	Dec 18, 2019	May 1, 2020	Mar 19, 2020	Feb 20, 2020	Feb 14, 2022	Feb 1, 2020
osimertinib -adjuvant EGFR	Feb 1, 2023	Jan 13, 2023	Feb 1, 2023	May 18, 2023	Nov 15, 2022	Nov 9, 2022	Mar 1, 2023	Feb 27, 2023	Sept 1, 2023	Nov 14, 2023	Jan 1, 2023
pembrolizumab squamous NSCLC	Jun 1, 2020	Sept 15, 2020	May 1, 2020	Apr 30, 2020	Jun 10, 2020	Sept 11, 2019	May 1, 2020	Jul 16, 2020	Jun 1, 2020	Jan 1, 2022	Not Funded
pembrolizumab non-squamous NSCLC	Jun 1, 2020	Sept 15, 2020	May 1, 2020	May 1, 2020	Apr 24, 2020	Apr 8, 2020	May 1, 2020	Jul 16, 2020	Jun 1, 2020	Jan 1, 2022	Not Funded
pralsetinib	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
selpercatinib	Sept 1, 2023	Aug 14, 2023	Sept 1, 2023	Aug 24, 2023	Jul 31, 2023	May 25, 2023	Nov 1, 2023	Sept 18, 2023	Dec 11, 2023	May 21, 2024	Jun 15, 2023
sotorasib	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
tepotinib	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Jul 6, 2023	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded

Current as of October 1, 2024

Table 3 — Number of Days from Date of FDA Approval to Date of Provincial Coverage

Food and Drug Administration (FDA) dates are provided as a reference to demonstrate the time it takes for provincial coverage from first approval in North America.

DRUG GENERIC NAME	FDA APPROVAL DATE	BC	AB	SK	MB	ON	QC	NS	NB	NL	PEI	NIHB
aleutinib - 1 st line	November 6, 2017	541	480	462	571	527	452	694	556	701	1,607	471
amivantamab	May 21, 2021	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
atezolizumab - adjuvant	October 15, 2021	686	598	594	599	628	545	650	636	627	971	Not Funded
atezolizumab - SCLC	March 18, 2019	1,536	1,312	1,444	1,444	1,453	1,122	1,592	1,493	2,024	1,914	Not Funded
atezolizumab - 2 nd line NSCLC	October 18, 2016	1,109	1,084	846	848	1,144	836	1,444	1,107	Not Funded	2,246	Not Funded
brigatinib - 1 st line ALK-positive	May 22, 2020	742	639	650	742	631	621	772	709	880	859	638
cemiplimab (PD-L1 ≥ 50%)	February 22, 2021	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
cemiplimab (any PD-L1)	November 8, 2022	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
crizotinib - ROS 1	March 11, 2016	1,573	1,740	2,668	Not Funded	Not Funded	2,596	1,757	1,582	1,512	2,509	1,946
dabrafenib & trametinib - BRAF V600F	June 22, 2017	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
durvalumab - stage III NSCLC	February 16, 2018	715	784	684	663	705	593	715	763	818	928	Not Funded
durvalumab - 1 st line ES-SCLC	March 30, 2020	915	807	828	842	844	828	842	856	915	1,099	Not Funded
entrectinib - ROS1	May 5, 2020	696	626	545	569	597	470	574	527	749	967	541
entrectinib - NTRK	August 15, 2019	1,478	Not Funded	1,355	1,470	1,370	Not Funded	1,508	1,411	1,508	1,755	1,373

DRUG GENERIC NAME	FDA APPROVAL DATE	BC	AB	SK	MB	ON	QC	NS	NB	NL	PEI	NIHB
larotrectinib	November 26, 2018	1,740	1,908	1,466	1,587	1,551	Not Funded	1,678	1,639	1,738	1,883	1,520
lorlatinib 1 st line	March 3, 2021	1,155	881	882	1,023	867	856	942	939	1,037	999	912
lurbinectedin	June 15, 2020	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
nivolumab neo-adjuvant NSCLC	March 4, 2022	699	528	576	580	558	572	576	574	Not Funded	752	Not Funded
nivolumab -ipilimumab MPM	October 2, 2020	576	546	576	546	613	516	668	629	607	790	Not Funded
nivolumab - ipilimumab (Opdivo - Yervoy®) 1L NSCLC	May 26, 2020	705	675	705	675	750	898	797	758	740	Not Funded	Not Funded
osimertinib - 1 st line	April 18, 2018	623	723	683	715	632	609	744	701	673	1,398	654
osimertinib - adjuvant EGFR	December 18, 2020	775	756	775	881	697	691	803	801	987	1,061	744
pembrolizumab squamous NSCLC	October 30, 2018	651	757	620	619	589	316	620	696	651	1,159	Not Funded
pembrolizumab non-squamous	August 20, 2018	651	757	620	620	613	597	620	696	651	1,230	Not Funded
pralsetinib	September 4, 2020	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
selpercatinib	May 8, 2020	1,211	1,193	1,211	1,203	1,179	1,112	1,272	1,228	1,312	1,474	1,134
sotorasib	May 28, 2021	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
tepotinib	February 3, 2021	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	883	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded

Current as of October 1, 2024

ACKNOWLEDGEMENTS

Lung Cancer Canada extends its heartfelt gratitude to the dedicated volunteers and advocates who contributed to this report.

To those with lived experience, thank you for sharing your stories of hope and resilience, which continue to inspire and uplift the lung cancer community. To the members of our Board of Directors and Medical Advisory Committee, our deepest appreciation for sharing your expertise, perspectives, and unwavering support.

Your collective efforts have made this report possible, and we are truly grateful for your commitment to improving the lives of those affected by lung cancer.

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Lung Cancer Canada is a national charity and the only one dedicated solely to lung cancer. It relies on donations to offer programs and services, such as this report, to persons living with lung cancer and their loved ones

Donations are greatly appreciated and a tax receipt is issued for a donation of \$20 or more. Donations can be made online at www.lungcancercanada.ca, or by calling the numbers on the back cover of this publication.

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