

Oral Oncolytic Care Plans in Medically Integrated Dispensing Pharmacies

Case Studies and Survey Results to Understand the Importance,
Utilization, and Variation of Oral Oncolytic Care Plans by Medically
Integrated Dispensing Pharmacies

Developed in collaboration between



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Introduction

The development and utilization of oral oncolytics has steadily increased over the past 20 years. There are over 800 new oncology therapies in the drug development pipeline, 25%-35% of which are oral agents.¹ The use of oral oncolytics presents unique challenges to patient safety compared to intravenous cancer treatments. As oral oncolytics are self-administered, it is important for the patient and caregiver to understand the appropriate dosing, frequency, duration of therapy, storage, and safe handling recommendations. Additionally, it is important for providers to explain the risks and benefits of the proposed therapy specific to each oral medication and to have an evidence-based plan for managing each patient on oral oncolytic therapy.

Due to the nature of how oral oncolytics are dispensed, there may be a higher burden on the patient and provider to coordinate care compared to intravenous therapies. For intravenous therapies, education is equally as critical, but care may be less fragmented and reduce the amount of coordination the patient and caregiver must handle themselves. Clear documentation of the plan of care for patients on oral oncolytic therapy can improve patient safety and impact patient outcomes.²

NCODA/Pfizer Survey Overview

Background

The National Community Oncology Dispensing Association (NCODA), in collaboration with Pfizer Oncology, developed a survey that was shared with its member organizations in May 2021 to better understand the oral oncolytic care plan development and management process for individual oral oncolytic agents. The objectives of the survey were to:

- Identify and define a medically integrated dispensing (MID) pharmacy oral oncolytic care plan
- Determine the percentage of NCODA members actively using oral oncolytic care plans in their practice
- Explore the development and management process for oral oncolytic care plans in a MID pharmacy
- Explore the variation that exists in oral oncolytic care plan detail, implementation, and maintenance

Respondent Characteristics

103 respondents who have MID pharmacies for oral oncolytics responded to the survey. Over 80% of the respondents were pharmacists or pharmacy technicians. Respondents were geographically diverse and included a mix of pharmacies with and without accreditations such as URAC, ACHC and QOPI.

Results

Results of the survey are included in the accompanying infographic “Oral Oncolytic Care Plans in Medically Integrated Dispensing Pharmacies”.

As the survey results in the infographic show, there was variation across respondents in the time commitment and resources dedicated to this component of patient care. NCODA and Pfizer wanted to better understand this variation and reached out to practices with established processes for care plan development to understand their current processes for developing and maintaining care plans along with opportunities for improvement. Additionally, NCODA and Pfizer wanted to better understand the need for a standardized oral oncolytic care plan template and the impact standardization could have on practice resources. Findings from those conversations are captured in the case studies.

PRACTICE CASE STUDIES

Practice Overview #1: Henry Ford Cancer Institute

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Ryan DasGupta, PharmD, BCOP: Clinical Pharmacy Specialist

Henry Ford Cancer Institute Summary

- Since 2014, the Oral Chemotherapy Management Program (OCMP) has grown to incorporate 42 oral oncolytic agents
- The Henry Ford Cancer Institute (HFCI) leverages their EHR, Epic, to integrate treatment plans into practice. Each treatment plan includes the required lab monitoring, any suggested dose reductions and interruptions, and other information that the staff deems important for that treatment plan.
- See appendix for an example outline of a treatment plan from HFCI
- HFCI estimates that it takes >5 hours to create and implement treatment plans
- Data collected by the HFCI team suggests patients enrolled in OCMP experience significant reductions in incidence and severity of capecitabine related adverse events

Overview

Henry Ford Cancer Institute (HFCI) has several locations across Michigan, including outpatient cancer centers and hospitals, to offer the latest advances in cancer care to patients across the globe. Pharmacy Advantage is Henry Ford's full-service Specialty and Mail Order Pharmacy. The pharmacy was established in 2007 and is now located in Rochester Hills, MI. Pharmacy Advantage is URAC accredited and ACHC accredited with distinction in Oncology. They provide services to over 10,000+ specialty patients. Amongst Henry Ford's several other ambulatory pharmacies, Pharmacy Advantage has comprehensive Medication Therapy Management Programs (MTM) to assist patients with acute and chronic conditions.

The Oral Chemotherapy Management Program

The pharmacy team at the Henry Ford Cancer Institute first started discussing an oral chemotherapy program in 2013. In 2014, they initiated the Oral Chemotherapy Management Program (OCMP) starting with two oral oncology agents, capecitabine and temozolomide. Their goal was to develop a program to improve safety and outcomes for patients on these complex treatments.

When developing the OCMP, the Henry Ford team knew it was important to have a cross functional team of stakeholders involved from the beginning. This included the clinical pharmacy team, the specialty pharmacy team, nursing staff, pharmacy benefit specialists, physician champions, and their internal Epic Beacon EHR system team. This group came together to create what they call "treatment plans*" using Epic Beacon to build and house these plans. These treatment plans are specific to each oral oncolytic therapy and are reviewed by providers within that specific discipline.

Creating a Treatment Plan for a New Drug

The creation of any treatment plan is largely initiated and executed by the clinical pharmacy team, including two "oral chemotherapy pharmacists" who identify new medications on the market. Once a new medication is identified, the team fills out Epic Beacon request forms, works with the Epic Beacon team to build the treatment plan, and works with providers and nursing staff to validate the treatment plan. Each treatment plan includes the required lab monitoring, any suggested dose reductions and interruptions, and other information that the staff deems important for that treatment plan. In addition

*Please note that Henry Ford Cancer Institute uses the term treatment plan instead of care plan

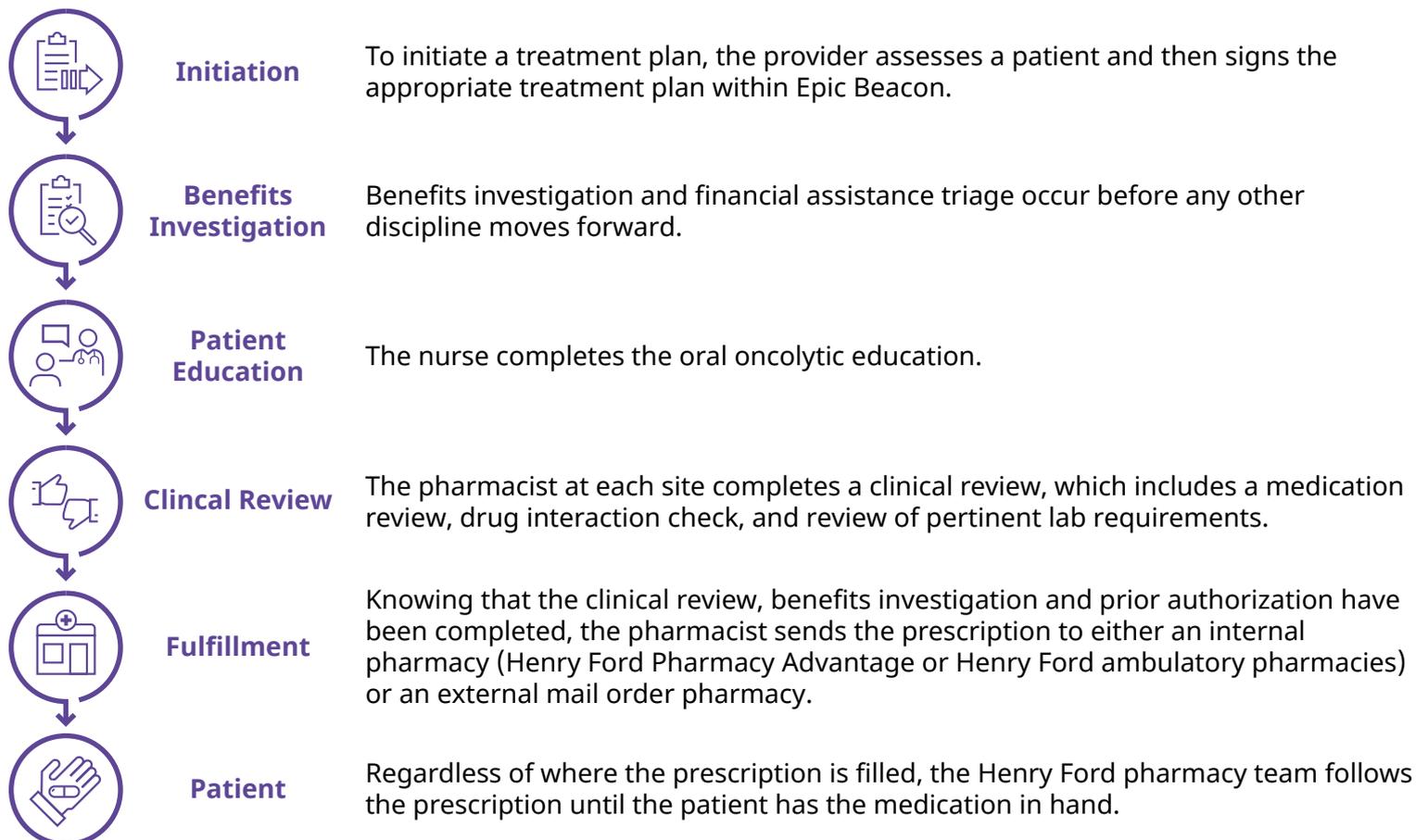
to the treatment plan itself, separate drug monitoring sheets are included for every drug within the plan. These embedded monitoring sheets serve as a resource to nurses and pharmacists to ensure they are completing appropriate assessments for the patient based on specific treatments. The monitoring sheets include questions that reference side effects specific to that medication, and may also refer the user back to a general questionnaire for common adverse events, like nausea, if it is a side effect of that medication.

According to the pharmacy team, it typically takes three hours to gather the data and identify the necessary components for a single treatment plan. When initially building each treatment plan, the pharmacist relies on data from clinical trials, National Comprehensive Cancer Network (NCCN) guidelines, and the package insert. Once drafted, the treatment plan is sent to the members of the oral chemotherapy group for review and validation. This group meets monthly; however, the validation of the oral chemotherapy treatment plan can happen via email to ensure implementation occurs as quickly as possible for each agent. The validation process adds an estimated 1-2 hours to the treatment plan development time. After the treatment plan is validated, it must be built in Epic which adds additional time. This process has been consistently refined since first being implemented in 2014, but the team believes that it still takes them over 5 hours to build and implement a single treatment plan for their OCMP program.

Maintenance of a Treatment Plan

Once implemented in Epic Beacon, the maintenance process for each treatment plan is still owned by the oral chemotherapy pharmacists. This process is standardized through the Clinical Protocol Review Committee which reviews all Epic Beacon treatment plans by disease state to ensure they are up to date. This committee meets monthly and cycles through all disease states on a rolling calendar. While some disease states may be reviewed more frequently than others, all treatment plans must be reviewed at least once every 3 years. Additionally, the oral chemotherapy pharmacists may make treatment plan changes between scheduled protocol reviews if they know guidelines or clinical data have changed.

Treatment Plans in Practice



Leveraging the EHR

The Henry Ford team credits Epic for allowing this process to be implemented and followed through the EHR. The team can utilize the “patient list” function to then follow the patient throughout their oral oncolytic treatment. The Patient List includes all patients currently enrolled in the OCMP. Each row in the list contains a single patient, their medical record number, oral chemotherapy regimen, which nurse is assigned to monitor the patient, the date they need to follow up with the patient, and custom notes regarding what tasks the nurse needs to complete at the next follow up. The list can be filtered by date so that a nurse can view their daily patients and tasks all at once. When a task is completed, the nurse can simply edit the date and the custom notes/tasks to move the patient to a later date for follow up. Examples of tasks within the Patient List include refills, toxicity assessments, lab monitoring, doctor visits, among other individualized patient needs. To facilitate handoff between nurses, the entire Patient List is accessible by any staff who may work within the OCMP.

While some improvements could be made from a technology standpoint, the team agrees that the treatment plan process currently meets most of their needs. When nurses and pharmacists are following up with patients, the monitoring sheets referenced previously are utilized. These monitoring sheets include a triage protocol based on grading of individual adverse events. This allows for the clinic nurses and pharmacists to triage patient issues using a standardized approach.

A Data-Backed Value Proposition

While the Henry Ford Cancer Institute has a robust oral oncolytic program providing highly specialized quality care for each patient, they acknowledge it hasn't come easily. The program is very comprehensive including treatment plans, monitoring questionnaires, and a detailed standard operating procedure (SOP) for patient follow up. Medications have been added slowly since initiating the program in 2014, which now includes 42 agents. With over 100 oral oncolytic agents on the market, the Henry Ford team continues to work diligently to build treatment plans but must do so with limited resources. As the number of agents included in the OCMP grows, the staff recognizes that some monitoring may need to be reduced to make room for agents that do not have treatment plans yet. An example may include reducing the monitoring requirements for patients who have been stable on therapy for a certain period of time. Like other cancer centers across the country, the Henry Ford team cites a lack of staff resources as a rate-limiting step to their OCMP growth.

For practices in the early stages of developing oral oncolytic treatment plans, the Henry Ford pharmacy team suggests starting with an inventory of the resources available. Once the scope of the process is determined (i.e., just managing patient education and first cycle follow up versus managing the patient throughout treatment), the next step is to develop a treatment plan for each individual agent. The Henry Ford pharmacy team started with capecitabine and temozolomide based on medication safety concerns and high utilization. From there, agents were identified based on utilization, complexity of the agent, and reported safety events. The team also tries to consider the disease state itself. For example, if a treatment plan for an oral oncolytic used in non-small cell lung cancer (NSCLC) was developed, they would try to prioritize all agents in that space. When asked about optimal next steps for the OCMP, the Henry Ford team identified that they are increasing staffing through newly approved positions. Once onboarded, they plan to continue building treatment plans for agents still awaiting program inclusion.

A recent publication in *JCO Oncology Practice* further details the impact of the OCMP on reducing adverse effects (AEs) in patients taking capecitabine. The Henry Ford team compared two groups of patients receiving capecitabine (one group before OCMP implementation and one group after OCMP implementation) in a retrospective study to measure the impact of the program. Patients enrolled in OCMP experienced lower incidence and severity of capecitabine-related AEs, such as nausea, vomiting, diarrhea, and hand-foot syndrome. Patients enrolled in OCMP also had significantly fewer emergency department visits and hospitalizations due to AEs.² Based on the results of this study, the Henry Ford team plans to continue to expand the OMCP and hopes to conduct prospective studies in the future.

Practice Overview #2: Florida Cancer Specialists

Roger Orr, PharmD, BCOP: Associate Director of Pharmacy Clinical Services

Florida Cancer Specialists Summary

- The physicians, clinical pharmacists, pharmacy technicians, patient assistance advocate team, and nursing staff all play key roles in oral oncolytic care plan development
- To develop a new oral oncolytic care plan, the pharmacist reviews dosing, common side effects, lab requirements, pertinent dose reductions or interruptions, drug interactions, dietary restrictions, storage and handling, and any supportive care recommendations for the specific agent
- The Rx To Go team estimates it takes more than 20 hours to develop and implement a single oral oncolytic care plan depending on the novelty of the agent and the resources available when drafting the care plan
- Maintaining the oral oncolytic care plans is a manual process within the pharmacy department based on post-marketing data, indication updates, and internal requests

Overview

Rx To Go Pharmacy was started in 2007 by Florida Cancer Specialists (FCS) with the vision to support their patients more effectively and efficiently. Rx To Go's purpose is to improve patient access to high-cost oral chemotherapy drugs and collaboratively work to improve patient outcomes for oral chemotherapy treatments. Today Rx To Go is dual accredited through URAC and ACHC, provides services to all FCS patients, and seeks to continuously improve the quality of that care. The oral oncolytic management process has been constantly evolving since Rx To Go opened, and they utilize a state of the art dispensing processes to ensure patients on oral oncolytics are provided the same high quality care regardless of where the patient is located. The oral oncolytic care plan is an integral part of ensuring patients at FCS are managed using a standardized approach for a specific treatment. The physicians, clinical pharmacists, pharmacy technicians, patient assistance advocate team, and nursing staff all play key roles in oral oncolytic care plan development and management at FCS.

Creating a Care Plan for a New Drug

The initial development of the oral oncolytic care plan is spearheaded by the Associate Director and Director of Pharmacy Clinical Services in an effort to meet the requirements and streamline documentation for Rx To Go's accreditations. When a new drug is approved by the FDA, the goal is to build the care plan within the first few weeks of approval. A clinical committee builds the initial treatment order set into the EHR, and the pharmacy team then utilizes the order set to aid in the development of the medication care plan. For example, if an order set is built into the EHR and it requires a baseline ECG, the baseline ECG parameters and review will be built into the medication care plan for the MID team. On average, the Rx To Go team estimates it takes more than 20 hours to develop and implement a single oral oncolytic care plan. The time requirement fluctuates depending on the novelty of the agent and the resources available when drafting the care plan. For example, if there is a new drug that requires specific electrolyte monitoring and they have already created those exact monitoring parameters for another drug in the same class, it may decrease the time required to develop the care plan. However, if there is a drug with a novel mechanism of action and adverse event profile, creation of the care plan may be more time intensive.

Maintenance of a Care Plan

Maintaining the oral oncolytic care plans is a manual process within the pharmacy department based on post-marketing data, indication updates, and internal requests. At a minimum, all care plans are reviewed annually by disease state. Additionally, if they are made aware of a change to the medication labeling, the pharmacy team will review and update the care plan accordingly. While FCS has a very robust care plan process, they still rely on manual alerts to trigger a maintenance review.

Using a Standard Templated Approach

Each of the oral oncolytic care plans is built from a standardized template to ensure all key components are incorporated and to minimize redundancies in documentation. Since both reassessments and care plans must be documented as part of accreditation standards, FCS builds oral oncolytic reassessments to incorporate patient-specific components prior to each refill (i.e., adherence checks) while the oral oncolytic care plans are medication specific and an additional resource when completing patient reassessments. Care plans are treatment specific, but they also leave room for clinical discretion based on patient specific factors. This can include referral to other areas for support. For example, FCS has their own dietitians that they recommend for some patients on specific drugs.

To develop a new oral oncolytic care plan, the pharmacist reviews:

- dosing
- common side effects
- lab requirements
- pertinent dose reductions or interruptions
- drug interactions
- dietary restrictions
- storage and handling
- any supportive care recommendations for the specific agent

This data is gathered from:

- clinical trials
- package inserts
- treatment guidelines
- medical information requests from the manufacturer

Challenges to a Standard Process for Care Plans

When asked about the barriers they experienced when developing this process, the Rx To Go team cited technology as the first hurdle. Access to the patient's EHR is crucial to providing quality patient care, so it's imperative that treatment documentation in the chart is thorough to ensure all stakeholders are on the same page. Also, the patient management software needed to communicate with the dispensing software, and all platforms needed to be easily accessible to all members of the healthcare team. The second pain point the Rx To Go team identified was the need to document all accreditation requirements without inundating the staff with duplicate tasks. Lastly, the group referenced the breakdown in care and communication that can occur if a patient is required to fill through an external mail order pharmacy as a barrier.

A Data-Backed Value Proposition

Like the Henry Ford team, FCS also published data on the real-world outcomes of their pharmacy-led oral oncolytic program. As part of this retrospective study, patients who started on afatinib were enrolled in the FCS patient management program and monitored according to the care plan. This intervention involved education from the pharmacy team with weekly follow-ups for up to the first 8 weeks of therapy and monthly follow-ups thereafter. The publication details how the pharmacy team managed afatinib-related AEs according to their protocols. Of the 120 patients who received afatinib, dose reductions were implemented in 61 patients (51%), and 16 patients (13%) ultimately discontinued afatinib due to an AE. Among patients who developed an afatinib-related AE, the large majority were able to remain on treatment for the duration of the analysis. The value of the program at FCS is demonstrated by the high rate of acceptance for interventions offered (85%). The continuous support provided by pharmacists enabled patients to manage their AEs more successfully and remain on treatment for a longer duration. The median duration of treatment in the group that discontinued treatment due to afatinib-related AEs was 4 months compared to 18 months for the group of patients who remained on therapy.³ By means of targeted assessment and proactive management of AEs, the pharmacy team can help patients better tolerate their prescribed medication and stay on the most clinically appropriate dose.

Discussion

Throughout the survey and practice overview process, a few key discussion points were repeatedly emphasized. The first point, and perhaps most notable, is the time and resource commitment a thorough oral oncolytic care plan requires. In the survey results, respondents identified wide ranges of time dedicated to care plan creation. The time and resource commitment were also noted during the case studies. After 7 years, Henry Ford's OCOMP encompasses 42 separate oral oncolytic agents. With over 100 oral oncolytic agents on the market, they are continuing to build and develop care plans. Similarly, FCS reported that some treatment care plans can take over 20 hours to develop and implement, depending on the complexity of the medication. Both Henry Ford and FCS have spent years finetuning their oral oncolytic care plan management and still struggle with having ample time and staff to devote to this process. Given resource concerns, standardized care plan templates may help to reduce the development burden on practices and reduce variation in the components included in care plans.

Another point mentioned in these discussions was the inconsistency in the available data for each treatment. Both practices relied heavily on clinical expertise and manual reviews to develop and maintain their care plans. Both groups also utilized package inserts, medical literature, and disease state guidelines to develop their care plans. However, the maintenance of those care plans is not automated since the trigger to do a maintenance review is based on the individual knowledge of a label change or guideline update. Along with the variability in maintaining care plans, both practices also noted the frustrations that can come from vague recommendations in the prescribing information. For example, if the package insert states to draw labs periodically, the teams are then faced with trying to come to a consensus on how to define "periodically" for their practice. In addition to developing a standardized template for oral oncolytic care plans, industry partners and oncology organizations could work together to eliminate vague guidance in the prescribing information. If a process was developed for an expert panel to come to a consensus on laboratory and testing cadences with each product on a national level, practices could develop care plans without having to pause and discuss each requirement on a system level.

Implementation Considerations

1. Time and resource commitment
2. Data inconsistency
3. Plan components and EHR integration

The third most common discussion point across the practices was the process of deciding what is included in each care plan and how to best integrate the plan into the EHR. When first starting their respective programs, each practice involved key stakeholders to determine the template for their care plans and discuss the implementation process. For both groups, the involvement of physicians, nurses, pharmacists, pharmacy technicians, and financial counselors is critical to the development of their oral oncolytic processes. The common components of their medication care plans included:

- Medication name
- Dosage
- Frequency
- Duration of therapy
- Drug-drug and drug-food interactions
- Common adverse events and how to manage toxicities
- Laboratory requirements
- Supportive care recommendations
- Dose adjustment guidelines
- Warnings and precautions
- Adherence assessment
- Recommended patient follow-up frequency.

Once the components of the care plan were agreed upon, each practice also had to consider how to incorporate the plans into their workflow. Fortunately, both groups had the support to utilize their EHRs to integrate oral oncolytic care plans into practice. While Henry Ford and FCS had different EHRs, they each had the ability to use their respective EHR programs to build what was needed to make their care plans functional, user-friendly, and automatic. While neither process is perfect, both groups are helping to lead the way in oral oncolytic management.

Appendix

Below is an example of a Treatment Plan at Henry Ford Health System. Each bullet is a separate order (some orders only contain information/text and no actual prescription). This displays Cycle 1, and all future cycles would be similar other than clinically indicated modifications.

Treatment Communication

- Blank order allows any health professionals to add comments regarding treatment

Provider Communications

- LAB MONITORING
- SUPPORTIVE CARE
- DRUG INTERACTIONS
- RENAL OR HEPATIC IMPAIRMENT

Treatment Parameters

- HOLD PARAMETERS FOR LAB ABNORMALITIES

Take-Home Chemotherapy Instructions

- Drug name, strength, frequency
- Administration instructions (i.e. food restrictions)
- Duration

Take-Home Medications

- Details for each supportive care agent (prescription and OTC recommendations)

Labs (standing orders in patient's chart so they can go to walk-in lab locations at their convenience)

Examples:

- Complete Blood Count and Differential: Weekly
- Comprehensive Metabolic Profile: Every 3 weeks
- Echocardiogram: Every 3 months

References

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2. Nhean S, Kostoff D, Yang J. Impact of oral chemotherapy management on capecitabine toxicity management. *JCO Oncol Pract*. 2021;17(7): e1021-e1029.
3. Khrystolubova N, Shieh M, Patel AJ, Bailey R. Pharmacist-led patient education and adverse event management in patients with non-small cell lung cancer receiving afatinib in a community based, real-world clinical setting. *J Oncol Pract*. 2019

Oral Oncolytic Care Plans in Medically Integrated Dispensing Pharmacies

Survey results to understand the importance, utilization, and variation of Oral Oncolytic Care Plans by Medically Integrated Dispensing Pharmacies

Survey, Background, Design, and Objectives

The American Society of Clinical Oncology (ASCO) has partnered with the National Community Oncology Dispensing Association (NCODA) to create joint evidence-based standards for Medically Integrated Dispensing (MID)* pharmacies. These standards focus on patient-centered care including patient relationships and education. Currently, Oral Oncolytic Care Plans† are not included in these standards, but may be an opportunity for MIDs to minimize variation in how patients are managed on specific oral oncolytics, helping to ensure that every patient gets the same level of care. NCODA, in collaboration with Pfizer Oncology, developed a survey that was shared with its member organizations to better understand the care plan development and management process for individual oral oncolytic agents. The objectives of the survey were to:

- Identify and define a MID pharmacy Oral Oncolytic Care Plan
- Determine the percentage of NCODA members actively using Oral Oncolytic Care Plans in their practice
- Explore the development and management process for Oral Oncolytic Care Plans in an MID Pharmacy
- Explore the variation that exists in Oral Oncolytic Care Plan detail, implementation and maintenance

*MID: A dispensing pharmacy within an oncology center of excellence that promotes a patient-centered, multidisciplinary team approach.

†For this survey, "Oral Oncolytic Care Plans" refers to an internal protocol for how to manage a specific oral oncolytic therapy.

Results are based on a survey of 103 respondents who have medically integrated dispensing pharmacies for oral oncolytics. Over 80% of respondents were pharmacists or pharmacy technicians. Respondents were geographically diverse and included a mix of pharmacies with and without accreditations (URAC, ACHC, and QOPI).

Importance

87% 

of respondents strongly agree or somewhat agree that care plans are crucial to quality patient care

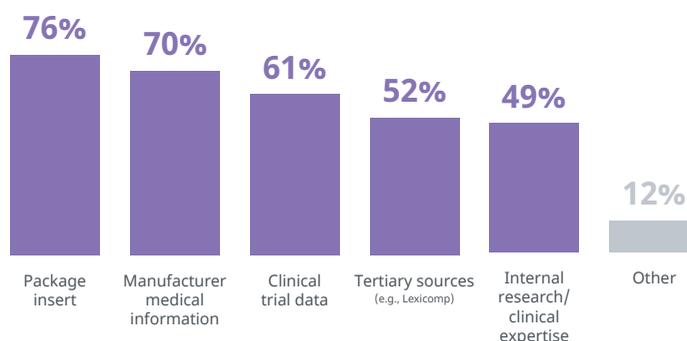
Tracking

32% 

of respondents do not track staff adherence to care plans

Resources[‡]

Respondents use a variety of resources for care plan development with package inserts and manufacturer medical information being the most common resources



[‡]Respondents were asked to identify what resources they use for developing care plans.

Management

76% 

of respondents identify that pharmacists, physicians or pharmacy technicians are responsible for Oral Oncolytic Care Plan development

Timeliness

86% 

of respondents implement care plans for new drugs within 1 month of drug approval

Implementation Time[§]

42% of respondents spend 6 or more hours developing and implementing product specific Oral Oncolytic Care Plans, while 58% spend less than 5 hours

(n=102)



[§]Respondents were asked how much time it takes to develop and implement care plans for newly approved oral oncolytics.

Components[¶]

As many as 15 components were identified as being part of Oral Oncolytic Care Plans. Over 60% of respondents include 10 or more of these components while 27% include 6 or fewer

- Dosing (89%)
- Adherence assessment (76%)
- Common adverse effects (75%)
- Refill management (75%)
- Adverse event management (72%)
- Patient follow up (71%)
- Dose modifications (70%)
- Administration (69%)
- Supportive care (69%)
- Drug interaction check (66%)
- Financial assistance (64%)
- Warnings/precautions (62%)
- Laboratory requirements (57%)
- Storage (53%)
- Other (6%)

[¶]Respondents were asked which components are currently part of their Oral Oncolytic Care Plans.

Barriers[#]

Respondents who do not have a standardized process for care plans identified different barriers to implementation

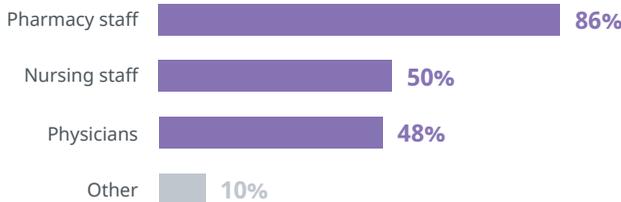
(n=23)



[#]Respondents who do not currently have a standardized process for patient management plans were asked about barriers to implementation.

Utilization^{**}

Pharmacy staff are the most likely to use care plans, but physicians and nursing staff also frequently use them

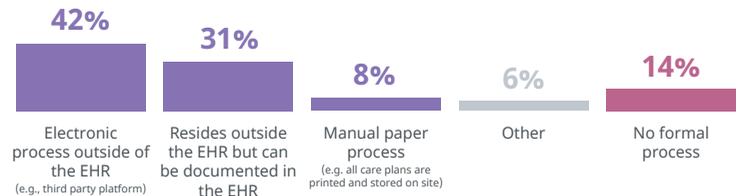


^{**}Respondents were asked who utilizes care plans in their practice.

Documentation

65%^{††} of respondents integrate care plans into their EHR. Those who do not integrate into their EHR use different methods including:^{††}

(n=36)

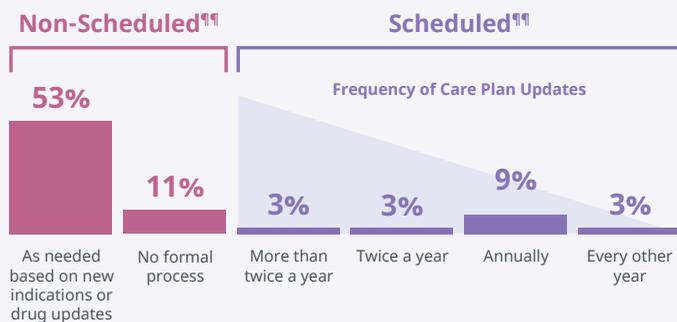


^{††}Respondents were asked if care plans are integrated into their EHR.

^{†††}The other 35% of respondents were asked how they implement care plans into their practice.

Frequency^{§§}

64% of respondents do not have regularly scheduled care plan updates

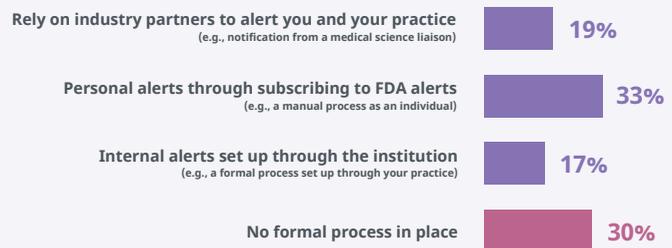


^{§§}Respondents were asked how often they update their care plans.

^{¶¶}18% of respondents use more than one of these approaches.

Tracking^{##}

30% of respondents indicate that they do not have a formal process in place for keeping track of updates to package inserts



^{##}Respondents were asked how they keep track of updates to package inserts.