FORUM REWIND

A LOOK BACK AT KEY SESSIONS FROM THE 2022 NCODA SPRING FORUM

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NCODA

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PROFESSIONAL STUDENT ORGANIZATION

Empowering The Future Generation of Oncology Leaders

> "Being a part of the NCODA Professional Student Organization (PSO) community is such a remarkable experience. Together, we keep each other updated and informed on current clinical oncology practices, while also providing opportunities that aid in developing leadership skills."
>
> **- Jonathan Rivera**
> PharmD Candidate | Class of 2023
> *University of North Texas Health Science Center*

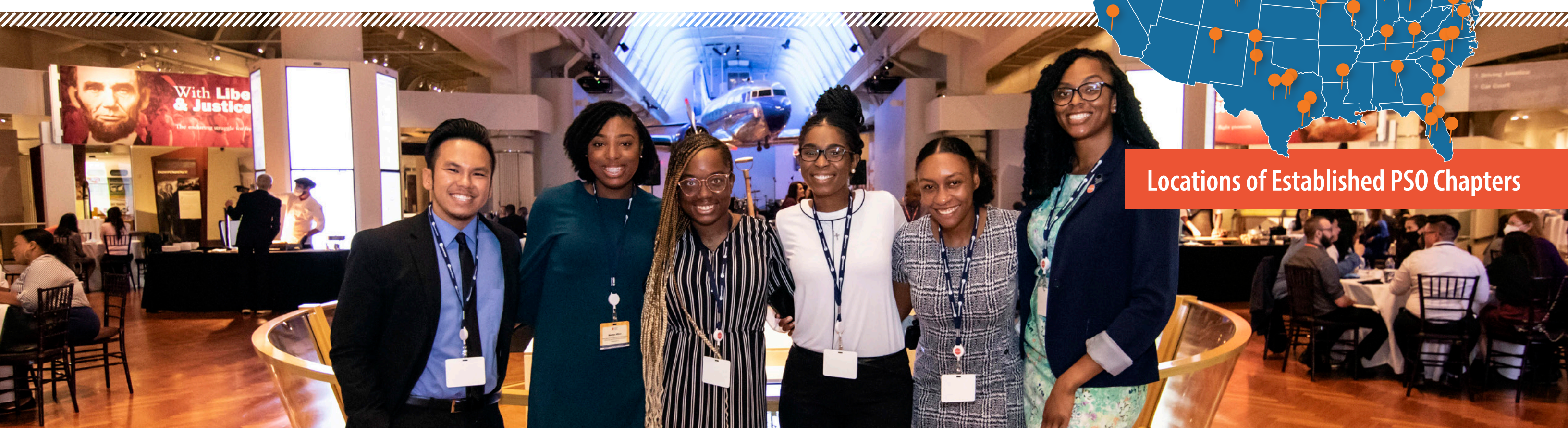
ABOUT PSO

Our focus is to offer an international community for healthcare students with a passion in oncology and pharmaceutical industry. The NCODA Professional Student Organization (PSO) was established for students interested in oncology, association management, healthcare advocacy and policy, and industry leadership.

PSO BENEFITS

- First professional student organization for students interested in oncology/association management/industry leadership
- Opportunities to attend NCODA international meetings
- International public presentation opportunities
- Create educational materials to help impact cancer care
- International publishing opportunities ***(ForumRewind, SummitRewind & Oncolytics Today publications)***
- Increased networking opportunities with oncology clinical and industry professionals, and key opinion leaders
- Access to over 50+ hours of oncology video education (Student Educational Talks)
- Oncology clinical practice experience and mentorship
- Healthcare advocacy and policy experience
- Additional student opportunities:
  - 1-year post-graduate oncology fellowships
  - International elective APPE rotation in oncology
  - Participate in NCODA's international clinical oncology competition

Locations of Established PSO Chapters



FOR MORE INFORMATION OR TO SUGGEST NEW CHAPTERS
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NCODA is a grassroots, not-for-profit organization, founded to strengthen oncology organizations with medically integrated pharmacy (MIP) services.

FORUMREWIND provides summaries of key sessions from NCODA's annual Spring Forum written by members of Professional Student Organization chapters from across North America. To view slides from presentations, scan the QR code at the end of the summaries.

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Diversity, Equity and Inclusion in Cancer Care

MODERATOR: Michael Reff, RPh, MBA | NCODA

PRESENTERS: Sybil Green, JD, RPh, MHA | American Society of Clinical Oncology; Kashyap Patel, MD | Carolina Blood and Cancer Care Associates; Luis Raez, MD | Memorial Cancer Institute

SYNOPSIS: The panel discussed the importance of addressing health disparities through diversity, equity and inclusion to overcome the barriers preventing optimal treatment outcomes.

PRESENTATION: Green, Patel and Raez explained that health disparities are the differences in the quality of healthcare across racial, ethnic and socio-economic groups. Disparities are a common and preventable problem that need to be addressed to achieve optimal therapeutic outcomes. Key health disparities include:

Access to care: Racial and ethnic minorities may face challenges in obtaining access to healthcare due to various barriers, including healthcare coverage, provider accessibility, access to linguistically and culturally appropriate care, and quality of care. The panel emphasized that even when adequate access to healthcare services is available, clinicians still need to consider the social determinants that can impact outcomes.

Social determinants: Even though cancer can be uniquely different for patients, social determinants can make their treatment even more diverse. Economic stability, social/community support, education, health literacy and nutritional support are social determinants that can put patients at a disadvantage, leading to inadequate screening, prevention and treatment outcomes.

Access to clinical trials: Pharmacogenomic differences between patients can lead to different responses in cancer treatments. The patient's age, gender, weight, ethnic origin and genetics all play a major role in how treatment may affect therapeutic outcomes. The inclusion of diversity among clinical trials can help improve poor treatment outcomes.

DISCUSSION:

Q: What strategies would you recommend when earning the trust of patients from minority populations when having them participate in clinical trials?

A: Put the patient first, remove implicit biases and communicate in a non-judgmental way to provide the highest quality of care to all cancer patients.

TAKEAWAY POINTS:

- Health information technology services aid in addressing social determinants of health.
- Seek to include underrepresented patient populations in clinical trials.

Summary by **Steven Upshaw**, PharmD Candidate (2023), University of Louisiana Monroe College Of Pharmacy.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.

NCODA's Center of Excellence Medically Integrated Pharmacy Accreditation

PRESENTER: Elizabeth Bell | NCODA; Brian Meger, PharmD | Minnesota Oncology; Kara Sammons, CPhT | Florida Cancer Specialists & Research Institute

SYNOPSIS: The presentation focused on NCODA's Center of Excellence (CoE) Medically Integrated Pharmacy (MIP) Accreditation and how it benefits patients and medically integrated pharmacies. Bell announced that Minnesota Oncology in Minneapolis has become the first NCODA CoE MIP accredited pharmacy.

PRESENTATION: The accreditation program was created to *Go Beyond the First Fill*. Going Beyond the First fill improves patient convenience, speed to therapy and followup, and adherence. As a result, the process leads to better outcomes and lower costs.

The accreditation program will expand to multi-specialty by the end of 2022.

NCODA CoE MIP Accreditation is overseen by the Executive Accreditation Council and the Accreditation Working Group. The accreditation process takes eight to 12 months.

DISCUSSION:

Q: How is the NCODA Center of Excellence Medically Integrated Pharmacy Accreditation different from other pharmacy accreditations on the market today?

A: It is the first and only accreditation that is specifically designed for medically-integrated pharmacies dispensing oral oncolytics and supportive care medications. The program reduces unnecessary administrative requirements and is less expensive than other available pharmacy accreditations. It is the preferred accreditation for Prime Therapeutics' IntegratedRx® Oncology Program.

Q: How many practices are accredited by NCODA at this time?

A: One practice, Minnesota Oncology, has completed the accreditation program. Several other pharmacies are still in the process of completing accreditation, while others have just started the process.

TAKEAWAY POINTS:

- NCODA CoE MIP Accreditation is compliant with the ASCO/NCODA Patient-Centered Standards for Medically Integrated Dispensing.
- The program has been recognized by Prime Therapeutics' IntegratedRx® Oncology Program as its preferred accreditation.
- The program has patient-centered and innovative standards and tools, and will soon provide accreditation templates and standard operating procedure manuals to assist practices with accreditation preparation.

Summary by **Jonathan Riveria**, PharmD Candidate (2023), University of North Texas Health Science Center College of Pharmacy.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.

Advanced Renal Cell Carcinoma: CLEARing Up First-Line Treatment

PRESENTERS: Jasmine V. Patel, PharmD, BCOP, Tashia Prince-Lacombe, MSN, AGNP-BC | Boston Medical Center

SYNOPSIS: The presentation focused on recognizing key differences and considerations between first-line treatments for advanced renal cell carcinoma (RCC), as well as significant toxicities with tyrosine-kinase inhibitors (TKIs) and immunotherapy (IO).

PRESENTATION: The incidence of RCC has increased over the past 50 years. It is now the ninth most common cancer in the United States.

Patel discussed the Memorial Sloan Kettering Cancer Center Prognostic Model and the International Database Consortium as important risk stratification analyses that highlight the increasing number of risk factors correlating to a poor prognosis.

Patel presented previous NCCN guideline recommendation options for patients with relapsed or stage IV and surgically unresectable RCC; pazopanib or sunitinib were the preferred regimens. Limitations of TKIs and IO should be considered when patient-specific factors play a role in guiding treatment and options are narrow.

Clinical trial data from four studies (KEYNOTE-46, CHECKMATE 9ER, CLEAR, CHECKMATE 214) was utilized to emphasize overall survival (OS), progression-free survival (PFS), objective response rate (ORR), as well as adverse event rates. Sunitinib was the comparator arm in all 4 clinical trials.

Prince-Lacombe examined higher percentages in OS and length of PFS with the TKI/IO combinations discussed. She also noted that ORRs were analogous throughout all regimens.

Discontinuation of therapy should be closely examined in all four trials due to risk of higher-grade toxicities or non-adherence. Patel identified distinguishable class effects of TKIs such as hypertension, hand-foot syndrome, diarrhea and thromboembolism events.

DISCUSSION:

Q: Do you ever consider empirically starting a patient at a lower dose of a TKI?

A: For healthier patients at baseline with few comorbidities, consider starting at the full dose. For older, less fit patients with anticipated tolerability issues, you may consider starting at a lower dose and titrating upwards based on their response.

TAKEAWAY POINTS:

• Compared to previous first-line therapy, combination IO/TKI regimens are preferred in advanced RCC.

Summary by **Salma Guerrero**, PharmD Candidate (2024), Texas Southern University College of Pharmacy & Health Sciences.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.

Be the MONARCH of Your Own DESTINY: Recent Updates in Breast Cancer

PRESENTER: Alison Palumbo, PharmD, MPH, BCOP | Oregon State University College of Pharmacy

SYNOPSIS: Palumbo discussed updates in metastatic HER2+ and adjuvant hormone-receptor positive breast cancer treatment based on the newly-published DESTINY-Breast03 and monarchE trials.

PRESENTATION: Palumbo provided previous standard of care for metastatic HER2+ breast cancer, including first-, second- and third-line treatment as indicated by the guidelines. She explained that fam-trastuzumab deruxtecan-nxki (T-DXd) replaced ado-trastuzumab emtansine (T-DM1) as a second-line Category 1 Regimen.

In the DESTINY-Breast03 trial, T-DXd was superior to T-DM1 in key endpoints such as progression-free survival, objective response rate and (immature) overall survival. Those treated with T-DXd experienced more treatment-emergent adverse events. Palumbo emphasized T-DXd is not interchangeable with other forms of trastuzumab and should not be diluted with sodium chloride.

For adjuvant treatment of horomone receptor positive hormone-receptor positive early breast cancer, Palumbo discussed the addition of abemaciclib to endocrine therapy (ET) compared to ET alone in the monarchE trial. Abemaciclib plus ET treatment was superior to ET therapy in invasive disease-free survival, distance relapse-free survival and (immature) overall survival. Those treated with abemaciclib and ET experienced more Grade 3 and Grade 4 serious adverse events. She suggested antidiarrheal and antinausea medications be considered when dispensing abemaciclib. She also noted that abemaciclib can be dispensed through a medically integrated pharmacy, and should be stored at room temperature.

DISCUSSION:

Q: Why do you think the treatments discussed could be new options for therapy despite the increase in adverse events?

A: Incorporation of these new treatments will be based on informed clinical decisions between the patient and their provider. It is important to determine if the benefits of these treatments outweigh the risk of increased adverse events.

TAKEAWAY POINTS:

• T-DXd was superior to T-DM1 in efficacy for metastatic HER2+ breast cancer in the DESTINY-Breast03 trial.

• monarchE suggests that abemaciclib is the first CDK 4/6 inhibitor that may improve outcomes in adjuvant treatment of high-risk HR+ HER2- breast cancer when added to endocrine therapy.

• Both T-DXd and abemaciclib have a higher risk of adverse events compared to current standard of care treatment. Refer to package inserts for proper compounding/dispensing.

Summary by **Javier Granados**, PharmD Candidate (2024), University of Texas at Austin College of Pharmacy.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.

Treatment of BRAF V600E Mutated and HER2-Amplified Metastatic Colorectal Cancer

PRESENTER: Makenna Smack, PharmD, BCOP | MD Anderson Cancer Center

SYNOPSIS: Smack analyzed relevant literature supporting the use of targeted therapies as treatment for HER2 positive and BRAF V600E mutated metastatic colorectal cancer (mCRC), which are both rare genetic mutations.

PRESENTATION: Targeted combination therapies for BRAF V600E mutated mCRC has evolved from triplet therapy to doublet therapy.

Smack discussed the BEACON trial, which included the combination of encorafenib, cetuximab and binimetinib. An improved overall response rate was reported compared to standard therapy in patients with metastatic colorectal cancer with the BRAF V600E mutation. However, toxicities were higher with the triplet therapy when compared with the doublet. HER2 amplified mCRC can only be indicated in KRAS/NRAS wild type CRC. Several HER2 targeted trials were noted. However, Smack focused primarily on the MyPathway trial. It indicated that dual HER2-targeted therapy with pertuzumab plus trastuzumab is well tolerated and could represent a good therapeutic opportunity for patients with mCRC as a second-line treatment based on guidelines.

Even though targeted therapies have shown promising outcomes for these different subtypes of mCRC, more research is still needed to determine the best treatment sequencing for patients.

Smack stressed that careful toxicity monitoring needs to be done on an individual basis with every patient since therapies for HER2 and BRAF have their own unique toxicities and could do more harm than benefit in some patients.

DISCUSSION:

Q: Regarding diarrhea management, what else can be used if loperamide is insufficient?

A: If loperamide is ineffective, the next step would be to utilize lomotil followed by the consideration of tincture of opium. Lastly, ocreotide could be considered in refractory settings.

TAKEAWAY POINTS:

- Treatment with targeted therapy requires a complete genetic profile workup to ensure appropriate patient selection and careful toxicity monitoring throughout therapy.
- Directed therapies for HER2 and BRAF have unique toxicities and require special monitoring.

Summary by **Nekoula Eldek**, PharmD Candidate (2023), Keck Graduate Institute School of Pharmacy and Health Sciences.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.

A Different EGFR Mutation (EGFR Exon 20) Requires New Treatment Approaches in NSCLC

MODERATOR: Ticiana Leal, MD | Emory Winship Cancer Center

PRESENTERS: Alyson Leonard, PharmD, BCPS, BCOP, CPP | Cone Health; Latha Radhakrishnan, PharmD, BCPS, BCOP | University of Illinois Cancer Center

SYNOPSIS: Radhakrishnan and Leonard debated the similarities and differences between using amivantamab or mobocertinib in patients with a non-small cell lung cancer (NSCLC) exon 20 insertion mutation.

PRESENTATION: Amivantamab and mobocertinib are subsequent therapy options for NSCLC patients with an exon 20 insertion mutation and disease progression on or after platinum-based chemotherapy. Both options have advantages and disadvantages, so it is beneficial to have a patient-centered care approach to identify the ideal patient for each treatment.

Amivantamab is an IV formulation that binds to epidermal growth factor (EGFR) and mesenchymal-epithelial transition receptors. This monoclonal antibody specifically binds to the receptor's extracellular domains, which allows for a bypass to resistance at tyrosine kinase inhibitor (TKI) binding sites. After the CHRYSALIS study, it was discovered that amivantamab provided therapeutic advantages in terms of objective response rate, median progression-free survival and overall survival. Radhakrishnan detailed how dose modifications are based on body weight if a patient has an intolerable adverse reaction.

Mobocertinib is an oral EGFR TKI that binds at two different sites, near the alpha C-helix and covalently to cysteine 797. This mechanism of action allows for the inhibition of five different variants of the EGFR exon 20 insertion mutation. During the clinical trial for mobocertinib, it was discovered that there were clinical benefits in patients with ≥ 6 months of control on a prior EGFR TKI. Mobocertinib also has a manageable safety profile, however, Leonard emphasized the importance of medication adherence when choosing an oral drug.

Both amivantamab and mobocertinib received accelerated approval by the FDA.

DISCUSSION:

Q: If you start with amivantamab, can you switch to moboertinib or vice versa?

A: According to guidelines, you can consider switching from one agent to the other at the point of progression.

TAKEAWAY POINTS:

- A patient-provider discussion involving patient preference is vital in determining which agent to use.
- Adherence concerns can play a part in deciding which agent to use.

Summary by **TaMar Hicks**, PharmD Candidate (2024), Texas Southern University College of Pharmacy & Health Sciences.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.

How Legislation Impacts Oncology: Identifying Disparities in the PBM System

MODERATOR: Melissa Dillmon, MD | Harbin Clinic

PRESENTERS: John Driscoll, MS | American Oncology Network; Barbara McAneny, MD | New Mexico Cancer Center / New Mexico Oncology Hematology Consultants; Allison Rollins, MSc | The US Oncology Network; Christie Smith, PharmD, MBA | AmerisourceBergen

SYNOPSIS: The presentation focused on the impact PBMs have on the healthcare industry. PBMs were created with the goal to manage pharmacy benefits in a way that would save both the hospital and the patient money, however they have been proven to do the opposite.

PRESENTATION: PBMs have become a primary source of complications for pharmacists and the care that they can provide. Rollins talked about Ohio's recent PBM audit, which reported a loss of more than $220 million from a single PBM. Other states have begun conducting audits and found similar results.

Panelists noted that the time immediately following an audit would be the most opportune time to develop new legislation.

When creating new legislation, McAneny emphasized that it is critical to be aware of the wordage behind potential PBM charges. McAneny suggested the state insurance commissioner would be an ideal ally to help with that process.

DISCUSSION:

Q: What key issues would you suggest we direct attention to?

A: The rising movement of reverse auctions, where the PBM negotiates with the state on insurance rates, and the state shares the quote in an effort to search for a lower cost option. But the consolidation has been rising so much that negotiation is not an option anymore.

Q: How has the pandemic impacted your work in policy?

A: Having the freedom to focus on your job while remaining prepared to testify through a virtual platform has allowed more people to predict when they may be heard, and as a direct result has led to an increase in testimony without time constraints.

TAKEAWAY POINTS:

- Testimony is a vital part of passing legislative initiatives.
- Put patients at the center of your radar and advocate for decisions that will protect them.
- NCODA's Legislation Tracking Tool is a great way to see how states across the country implement legislation.

Summary by **Hala Daghlas-Yusuf**, PharmD Candidate (2023), Northeast Ohio Medical University College of Pharmacy.

Scan QR code to view NCODA's comprehensive Oncology State Legislation Tracker.

Prior Auths and Multiple Appeal Process: How to Build a Stronger Appeal

PRESENTERS: Lesli Goebel, PharmD, CSP | Billings Clinic; Natasha Khrystolubova, RPh, BPharm, BCOP | Florida Cancer Specialists & Research Institute; Jeanie Maleski, LPhT, RPhT | American Oncology Network; Lindsey Scott, R.CPhT | Texas Oncology; Amy Terhune, CPhT | Florida Cancer Specialists & Research Institute

SYNOPSIS: The panelists explored precision medicine's applicability in cancer and the expanding therapy choices it provides. Precision medicine, like other innovations, has its own set of obstacles and uncertainties. The panelists explored some of these issues and how they plan to overcome them in order to obtain prior authorization (PA) and enhance cancer patients' health outcomes as quickly as possible.

PRESENTATION: The panelists reviewed the associated PA concerns after a brief introduction to precision medicine and its progress and milestones since 1991. The benefits of liquid biopsy in tumor detection was highlighted.

The panelists discussed the constant growth of new genomic targets in oncology, new therapies, different biopsy techniques and their applications in oncology.

Precision medicine is highly specialized and constantly evolving. Because of this ever-changing dynamic, communication between the practice and insurance can be a challenge, particularly during the PA process.

Panelists discussed the PA submission process and strategies for dealing with PA denials. Some insurances offer peer-to-peer review in such cases, others require an appeal. Appeals need to be as specific as possible. It's important to explain to the physician that their notes must clearly detail why a particular therapy is required, and not simply rehash points included in the original denial. Should the appeal be denied, a second-level appeal is the next option, followed by external review. The panel noted that external reviews often uphold the denial. Free drug applications are an option while awaiting a decision on an appeal.

TAKEAWAY POINTS:

- Different insurance companies have different portals and different processes to handle PAs.
- Digital libraries can be employed to assist practices in developing a strong PA.
- The PA process requires teamwork and profound communications skills.
- Every PA in oncology is urgent and should be mark as urgent.
- Appeals must clearly explain why a particular therapy is needed; avoid repeating the same points from the original denial.

Summary by **Nicole Maham**, PharmD Candidate (2023), Shenandoah University, Bernard J. Dunn School of Pharmacy.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.

Navigating Value-Based Contracts

PRESENTER: Barry Brooks, MD | Texas Oncology

SYNOPSIS: Brooks discussed advantages of value-based programs, as well as the challenges of establishing them.

PRESENTATION: Value-based care means different things to different people, Brooks said. He defined the concept as a "less is more" approach to treatment that is economical and not wasteful in spending, but at the same time is not excessively frugal. "Excessive spending is just as bad as inadequate spending," Brooks said.

Texas Oncology is part of the US Oncology Network. The network uses the term "Goldilocks" for its preferred products and pathway choices — "The drug that fits all the criteria, that has low cost and nice margin for the practice, and has a low coinsurance or copay," Brooks said. "In other words, just right."

The Network focuses on total cost of care, using less expensive, but equivalent medicines. It utilizes biosimilar substitution when appropriate and equivalent generics when available. Its pathways pursue the most effective, least toxic and least costly drug options. These pathways are evidence-based, reduce variation and address novel therapies, biomarkers, etc. Multiple oncologists from throughout the network collaborate on pathway decisions.

The Network uses state-of-the-art technology, including telemedicine and virtual care, to deliver high-quality, cost effective cancer care.

Adopting value-based care is not a simple decision; the network's model is based on a complicated, evolving algorithim. Participating network practices showed significant cost improvement over time.

Pefilgrastim was cited as a drug management example. Since it is not indicated for solid metastatic tumors, the network does not use it in the vast majority of those cases.

The Network's use of biosimilars has increased to 90% since Q1 2020, contributing to several million dollars in savings, Brooks noted.

The Network is able to bend the cost curve by focusing on quality patient care. It strives to minimize service and chemo drug costs, and avoid hospital utilization. It also emphasizes advance care planning and end-of-life support.

TAKEAWAY POINTS:

- Improvements in care with measurable outcomes are vital in value-based care.
- Practices can partner together to bend the cost curve through a focus on quality patient care.
- Practitioners should innovate to increase gains in adherence and persistence.

Summary by **Audrey Simon**, PharmD Candidate (2023), University of Toledo College of Pharmacy and Pharmaceutical Sciences.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.

Integrative Medicine In Cancer Care: Optimizing Your Patients' Experience

PRESENTER: Stephen C. Farley, PharmD, BCOP | Geisinger Commonwealth School of Medicine

SYNOPSIS: Farley provided an overview of evidence-based integrative medicine that can be used by cancer patients as adjunct treatment to their conventional care.

PRESENTATION: Farley said that while advances in cancer detection and treatment have improved survival rates, surviving cancer causes stress and anxiety regarding recurrence and predisposes patients to treatment adverse events. He introduced the notion of integrative medicine, which combines evidence-based proven complementary therapies with conventional medicine.

Farley talked about how mind and body therapies (MBTs) such as Tai Chi and yoga are a group of healing techniques that enhance the mind's interactions with bodily functions, improving overall quality of life. Clinical trials have shown that MBTs can reduce markers of inflammation and decrease expression of inflammatory genes.

Farley discussed complementary therapies such as herbs, vitamins and other over-the-counter supplements which may be either helpful or harmful to patients and thus can be challenging to manage, raising concern about their long-term use.

For instance, dong quai, an herb root with long history of use in traditional Chinese medicine for menstrual and menopausal symptoms, can stop estrogenic activity in vitro, but prolonged use can induce CYP3A4 enzyme levels.

Lastly, he highlighted resources for healthcare providers that can be used to manage these therapies, including Memorial Sloan Kettering's "About Herbs" application and the Society for Integrative Oncology.

DISCUSSION:

Q: How do you get buy-in from providers and administrators to initiate these therapies within your practice?

A: Continue to advocate for the patient, and have patients share their positive experiences with complementary therapies with their physicians.

TAKEAWAY POINTS:

• Integrative medicine encompasses non-pharmacologic therapies that can be used adjunctively to conventional cancer care for symptom control.

• While supplements can be helpful for certain cancer patients, caution must be taken due to potential drug-drug interactions.

Summary by **Katarina Pessina**, PharmD Candidate (2023), University of Toronto, Leslie Dan Faculty of Pharmacy.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.

Integrative Oncology: Whole-Person Care

PRESENTER: Dwinelva Zackery, LCSW, LISW-S, RYT, CHC | St. Elizabeth Cancer Center

SYNOPSIS: Zackery discussed integrative oncology — a patient-centered, evidence-informed field of cancer using natural, lifestyle and mind/body practices alongside conventional cancer treatment.

PRESENTATION: Zackery provided information on the benefits of integrative oncology for patients, as well as demonstrated services that her outpatient community cancer center uses for patients.

Integrative oncology allows patients to be empowered as an active member in their care, resulting in better outcomes. This technique improves quality of life, reduces anxiety and decreases symptoms of stress.

The St. Elizabeth Cancer Center in Edgewood, Kentucky, uses a nutrition demonstration kitchen, exercise classes, mindfulness-based stress reduction (MBSR) and acupuncture in its integrative oncology program.

The kitchen provides classes to teach patients about nutrition, and how to better cook and eat while undergoing therapy. The exercise classes include yoga and tai chi, which help patients gain more energy amidst their fatigue. MBSR is a combination of meditation, yoga and exploring behavior. Acupuncture is effective for nausea, vomiting and neuropathy.

Zackery also discussed a patient-centered approach in which patient and provider communication is key. One aspect of this approach is the Cancer Patient & Family Advisory Committee, a group that uses the voice of the family for committee meetings.

DISCUSSION:

Q: If you had to pick one of your services, which one do you feel is the most impactful?

A: Acupuncture and the demonstrative cooking kitchen.

Q: If you are newer to this space but wanted to start a program, who are the key stakeholders to bring to the table and how do you start these conversations?

A: St. Elizabeth Hospital focused on community — key stakeholders included the administration and medical director. Make sure that leadership is on board before starting.

TAKEAWAY POINTS:

• Integrative oncology and everything it offers to patients can be the key to successfully optimizing their quality of life.

• Yoga and tai chi have the potential to help patients address their levels of fatigue.

Summary by **Michelle Johnston**, PharmD Candidate (2023), University Of Cincinnati, James L. Winkle College of Pharmacy.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.

Using Technology to Improve the Safety, Quality and Productivity of Sterile Compounding

PRESENTER: Howard Cohen, RPh, MS, FASHP | Safe Medication Management Associates

SYNOPSIS: Cohen discussed the introduction of IV workflow management systems, including robotics, and how these innovations could enhance pharmacy workflow, safety and standardization of sterile compounding.

PRESENTATION: Cohen reviewed the current system of sterile compounding and the pitfalls of the manual compounding process. These include technician injury, exposure to hazardous medications and the regulatory compliance requirements associated with USP 797 and USP 800.

The addition of innovation in the healthcare setting can enhance pharmacy workflow and improve efficiency. The robotics and IV workflow management systems do not replace technicians, but free them to focus on other essential tasks. Staff may resist new technology by raising concerns about additional steps to the process. However, with time, the efficiency of the workflow will prevail.

The new technology is expensive, but planning each step of the process can help build return on investment for their implementation. IV workflow management systems include barcode verification of products used in compounding, digital imaging of each step of the process and gravimetric validation.

Implementing the technology will assist in the standardization of the compounding process and increase quality and productivity overall. Getting to know the product and its strengths and limitations will help set realistic goals for the use of such technology. Implementing dose banding, advance ordering and batching will increase practice volumes and allow for patient-specific doses to be manually compounded.

DISCUSSION:

Q: What steps help reassure technicians that the technology is not their replacement?

A: Communication, highlighting the system's benefits and involving staff are critical. Find a staff champion who can use the robot and initiate ongoing training and communication. Include a robot naming contest to encourage staff use.

TAKEAWAY POINTS:

- Planning is critical when deciding on new robotic technology.
- Communication is key to implementing new technology and reducing staff resistance.

Summary by **Susan Udoessien**, PharmD Candidate (2024), Creighton University School of Pharmacy and Health Professions.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.

Improving Care Coordination for Patients on Oral Oncolytic Therapy

PRESENTERS: Olivia Barrett, RN, Jonas Congelli, RPh, Stacy Keppler, PharmD, Anthony Scalzo, MD | Hematology Oncology Associates of Central New York

SYNOPSIS: The presentation focused on the misalignment of oral oncolytics with office visits and dispensing. The coordination of palbociclib was highlighted. However, the same measures apply to all oral anticancer medications managed by the practice.

PRESENTATION: Approximately 55% of dispenses for palbociclib occur outside of the specified time frame for office visits, resulting in inefficient care, wasted resources, poor patient satisfaction and frustration for both patient and staff. The aim was to increase coordinated office visits from 45% to 80%.

Barrett recommended implementation of such measures as medication pick up, visual stop signs and the walking of patients to the outpatient pharmacy.

Keppler suggested a "Stop" at the end of the appointment before the medication is dispensed to enable an alignment of labs, scans, follow ups, or infusion and oral cycles.

Barrett emphasized the importance of aligning care plans with cycles. Regarding orals, the Electronic Medical Record is set up on a 28-day cycle, while some medications are on 30-day cycles. After a few weeks of treatment, the patient's schedule will be off by a week and the pharmacist must manually correct this. Aligning orals with infusions can be even more difficult.

Key considerations for sustainability of high-quality care are improved communication across interdisciplinary teams, regular data review, and keeping oral oncolytic prescriptions within the medically integrated pharmacy.

The increased alignment of palbociclib improved accuracy and visibility of treatment plans, and fostered a culture of continuous improvement.

DISCUSSION:

Q: How has the alignment helped patients?

A: Scalzo provided an example where medication was dispensed to a patient. Ten days of the prescription were taken with 11 days remaining, however the patient's progression was not taken into consideration due to an appointment misalignment. This situation now can be prevented under the new alignment, saving the patient both time and money.

TAKEAWAY POINTS:

- Oral oncolytics require complex management and coordination.
- Oncology teams should work across a care continuum to leverage their medically integrated team.

Summary by **Michaela Sattaur**, PharmD Candidate (2022), Albany College of Pharmacy and Health Sciences.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.

New Options for Patients: 2022 Oral Oncology Update

PRESENTER: Robert Wilkinson, PharmD, MS, BCPS, BCOP, BCIDP | Memorial Hospital West

SYNOPSIS: Wilkinson discussed novel oral oncolytics and expanded indications approved within the last year.

PRESENTATION: (see table at right)

DISCUSSION:

Q: Regarding new oral oncolytics, what is the pharmacist's primary role in managing patients?

A: The most important thing is to immediately look at the warnings and precautions. Be proactive with patient care and anticipate what problems patients on these drugs could experience.

Summary by **Mattie Kilpatrick**, PharmD Candidate (2023), Auburn University, Harrison School of Pharmacy.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.

Novel Drug	Approval Date	FDA Approval	Indication
Asciminib	10/29/2021*	Chronic Myeloid Leukemia (CML)	Ph+ CML in chronic phase with T315I mutation or previously treated with ≥2 TKIs
Mobocertinib	9/15/2021*	Non-Small Cell Lung Cancer (NSCLC)	Locally advanced or mNSCLC with EGFR exon 20 insertion mutations^{+}
Belumosudil	7/16/2021	Chronic Graft-Versus-Host-Disease (cGVHD)	Age ≥12 with cGVHD^{+}
Infigratinib	5/28/2021*	Cholangiocarcinoma	Unresectable, locally advanced or metastatic cholangiocarcinoma with FGFR2 fusion or other rearrangement^{+}
Sotorasib	5/28/2021*	NSCLC	KRAS G12C-mutated locally advanced or mNSCLC^{+}
Tivozanib	3/10/2021	Renal Cell Carcinoma (RCC)	Relapsed or refractory RCC^{+}
Tepotinib	2/3/2021*	NSCLC	mNSCLC harboring MET exon 14 skipping alterations
Existing Drug	**Approval Date**	**Original Indication**	**Expanded Indication**
Olaparib	3/11/2022	Breast cancer	Adjuvant - Deleterious (or suspected) germline BRCA mutated, HER2- negative breast cancer
Abemaciclib	10/12/2021	Breast cancer	Adjuvant with endocrine therapy- HR-positive, HER2-negative, node-positive breast cancer
Ruxolitinib	9/22/2021	Polycythemia vera	Age ≥ 12 with cGVHD^{+}
Cabozantanib	9/17/2021	RCC	Age ≥ 12 with local advanced or metastatic differentiated thyroid cancer^{+}
Zanubrutinib	9/14/2021*	Mantle cell lymphoma	R/R marginal zone lymphoma^{+}
	9/1/2021		Waldenström's macroglobulinemia
Ivosidenib	8/25/2021	Acute myeloid leukemia	Locally advanced or metastatic cholangiocarcinoma with IDH1 mutation
Lenvatinib	8/10/2021	Thyroid cancer	Advanced RCC (first-line treatment + pembrolizumab)
	7/21/2021		Advanced endometrial carcinoma^{+} (+ pembrolizumab)
Avapritinib	6/16/2021	Gastrointestinal Stromal Tumor (GIST)	Advanced systemic mastocytosis, systemic mastocytosis with an associated hematological neoplasm, and mast cell leukemia

* Approved through FDA Accelerated Approval Program + Previous therapy failure required for use

Putting Positive Quality Interventions Into Action: Consistent Clinical Standards & NCODA Resources for Medically Integrated Teams

MODERATOR: Ginger Blackmon, PharmD | NCODA

PRESENTERS: Kayla Boyd, PharmD, BCOP | Kaiser Permanente; Chris Elder, PharmD, BCOP | Florida Cancer Specialists & Research Institute; Joy Gray, PharmD | Tennessee Cancer Specialists; Jenny Pearson, PharmD | Oncology Consultants; Christina Patterson, PA-C | Cancer Care Associates of York

SYNOPSIS: Boyd talked about Positive Quality Interventions (PQIs). Elder talked about Oral Chemotherapy Education (OCE) and Intravenous Cancer Treatment Education (IVE) sheets. Pearson discussed Treatment Support Kits (TSKs). Patterson and Pratt discussed PQI In Action.

PRESENTATION: Boyd provided an overview of PQIs. A PQI is a concise clinical guidance document that is peer-reviewed and updated twice a year (minimum). Once a PQI is written, it goes to the PQI clinical committee. After review, it is published on the NCODA website.

Currently, there are more than 80 PQIs available, including 73 on medications, 11 on supportive care and five on disease states.

Elder spoke about NCODA patient resources, OCE and IVE. IVE is divided into two categories: solid tumors and hematologic malignancies. Within these two categories there are IVE sheets for 33 regimens currently available.

Pearson discussed NCODA's TSKs. A TSK is a supportive kit for cancer patients to help improve medication adherence.

Each TSK includes educational information and products the patient can use to manage adverse events. Kits are available for both branded and generic products. NCODA is an FDA-registered kit manufacturer.

Patterson and Pratt discussed PQI In Action and MID. Both presenters utilize PQIs at their practice sites. With the help of the PQI, they can counsel patients on their medications, as well as on potential adverse effects.

TAKEAWAY POINTS:

• NCODA has developed consistent clinical resources for both oncology healthcare professionals and cancer patients.

• If you are interested in utilizing any of the resources discussed, visit www.ncoda.org or email contact@ncoda.org.

Summary by **Jake Boan**, PharmD Candidate (2023), University of Missouri-Kansas City School of Pharmacy.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.

NCODA Publishes Case Studies on Adherence Risk Assessment / Management & Care Plan Development for Patients Receiving Oral Oncolytic Therapy

Case study articles highlight the results of a May 2021 member survey conducted by NCODA and Pfizer Oncology, with detailed practice summaries from Mayo Clinic (Rochester, Minnesota), Billings Clinic (Billings, Montana), Henry Ford Cancer Institute (Detroit, Michigan), and Florida Cancer Specialists & Research Institute (Fort Myers, Florida).

Oral Oncolytic Adherence Risk Assessment / Management Case Study

KEY POINTS

- Patients at high-risk of non-adherence are identified via informal assessments during the patient education session
- Assessing patient adherence is often reliant on patient self-report, and there is a need for a more formalized tool
- There are limitations to the utilization of current adherence metrics like MPR and PDC

Scan QR code to access case study

Oral Oncolytic Care Plan Development Case Study

KEY POINTS

- Leveraging the electronic health record is crucial to the development of a thorough medication care plan
- Developing and maintaining drug-specific care plans can be a time-intensive process that relies heavily on pharmacy staff staying up to date on regimen changes
- Data suggests that patients managed according to a care plan experience significant reductions in incidence and severity of adverse events

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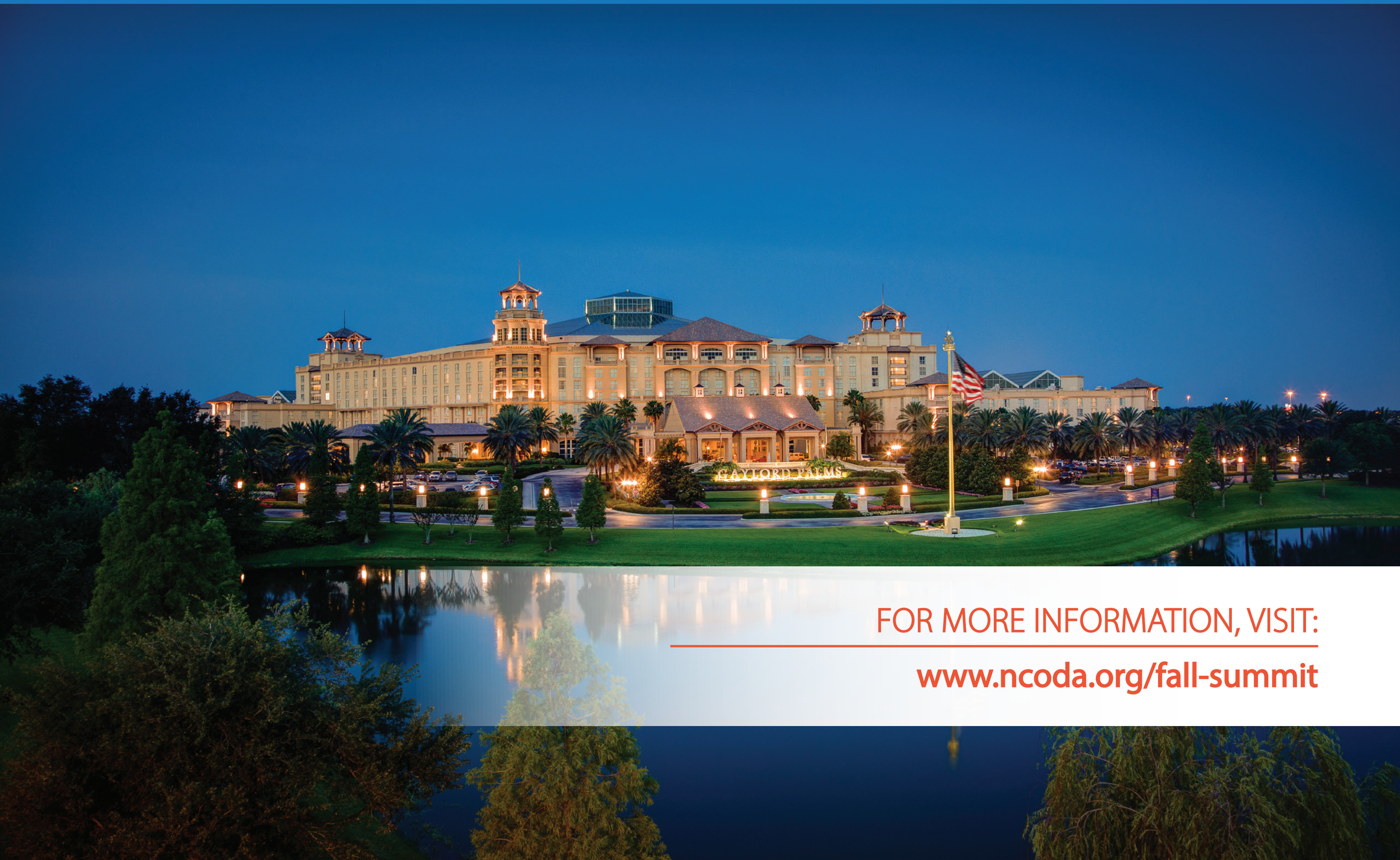

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