

NCODA's POSITIVE QUALITY INTERVENTION IN ACTION>>>>>

**MULTIDISCIPLINARY MANAGEMENT OF
ADVANCED OVARIAN CANCER PATIENTS
WITHIN MEDICALLY INTEGRATED
PHARMACY PRACTICES**



National Community Oncology
Dispensing Association, Inc.
PASSION FOR PATIENTS
NCODA.ORG

NCODA's POSITIVE QUALITY INTERVENTION IN ACTION >>>>

INTRODUCTION

In an effort to promote higher quality patient care, the National Community Oncology Dispensing Association, Inc. (NCODA), created the NCODA Positive Quality Intervention (PQI) as a peer-reviewed clinical guidance document for healthcare providers. By providing Quality Standards and effective practices around a specific aspect of cancer care, PQIs equip the entire multidisciplinary care team with a sophisticated yet simple-to-use resource for managing patients receiving oral or IV oncolytics. The PQI fosters better care for patients through appropriate patient identification, selection, increased speed to therapy, reduced cost and hospitalization and by improving adherence techniques for the patient and their medically integrated teams.

MULTIDISCIPLINARY MANAGEMENT OF ADVANCED OVARIAN CANCER PATIENTS WITHIN MEDICALLY INTEGRATED PHARMACY PRACTICES

The PQI in Action incorporates opinions and experiences from oncology experts within the medically integrated teams at six leading care organizations. These cancer treatment organizations have successfully implemented medically integrated pharmacies (MIP) as well as the use of Positive Quality Interventions throughout their care teams to improve the clinical outcomes of patients receiving niraparib and other therapies for maintenance treatment of advanced ovarian cancer.

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Practice panelist's comments reflect their experiences and opinions and should not be used as a substitute for medical judgement.

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MEDICALLY INTEGRATED PHARMACY

Medically Integrated Pharmacies (MIP) are a type of service model in which patients receive oral therapies at the site of care with their doctor and are managed by one staff; state-of-the-art pharmacy services are built within the oncologist's office that help to deliver timely and ongoing care as part of a single, multidisciplinary team. Complexity of cancer treatment has recently increased with a growing number of both oral and IV therapies which are delivered across an often-confusing, payer-driven healthcare system. Connectivity through the Electronic Medical Record (EMR) enables healthcare professionals to continuously interact and make decisions based upon the latest medical information available for the patient. With an ever-growing amount of information to process and disseminate to patients and colleagues alike, oncology professionals need tools like NCODA's Positive Quality Intervention to assist them in delivering sophisticated care. In advanced ovarian cancer, disparities exist in the percentage of patients who are genetically tested and also with those patients who are offered maintenance therapy when appropriate^{1,2}. The PQI offers a solution.



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National Community Oncology Dispensing Association, Inc. (NCODA), has developed this Positive Quality Intervention in Action platform. This platform represents a brief summary of medication uses and therapy options derived from information provided by the drug manufacturer and other resources. This platform is intended as an educational aid and does not provide individual medical advice and does not substitute for the advice of a qualified healthcare professional. This platform does not cover all existing information related to the possible uses, directions, doses, precautions, warning, interactions, adverse effects, or risks associated with the medication discussed in the platform and is not intended as a substitute for the advice of a qualified healthcare professional. The materials contained in this platform are for informational purposes only and do not constitute or imply endorsement, recommendation, or favoring of this medication by NCODA, which assumes no liability for and does not ensure the accuracy of the information presented. NCODA does not make any representations with respect to the medications whatsoever, and any and all decisions, with respect to such medications, are at the sole risk of the individual consuming the medication. All decisions related to taking this medication should be made with the guidance and under the direction of a qualified healthcare professional.

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OVARIAN CANCER

A patient's journey after diagnosis with ovarian cancer can take many paths. NCODA created this project to identify effective practices with promise for improving patient outcomes. The Positive Quality Intervention on PARP-Inhibitor (PARP-I) Eligibility enables MIP teams to better understand the ovarian cancer space. A retrospective study of 4,950 patients showed a

genetic testing rate of 50%¹. Another retrospective data analysis showed that 49% of patients received maintenance therapy in second line or greater therapy³. Current rates warrant improved methods and practices to enable professionals to offer excellence to their patients; the PQI provides consistent clinical guidance information to improve outcomes.

GENETIC TESTING: A STANDARD

A study published in the Journal of Clinical Oncology estimated that 1.2-1.3 million eligible patients are not offered BRCA testing⁵. Because genetic testing was not previously a standard recommendation, untested patients with recurrence should be tested and evaluated appropriately. Many factors affect recurrence of disease including the primary site and method of treatment⁶. A study done by Randall and colleagues found 50% of women with epithelial ovarian cancer underwent BRCA1/2

testing, while Buchanan and colleagues found testing rates in this patient population to be close to around 75%. Identified barriers to testing included older age and noncompliance with health screenings¹⁷. Current NCCN guidelines for genetic testing recommends BRCA testing in all ovarian cancer patients⁸. An effective practice to highlight is standard referral to a genetic counselor for specific testing recommendations for patients.



A GENETIC COUNSELOR PROVIDES SPECIFIC TESTING RECOMMENDATIONS FOR PATIENTS.

MAINTENANCE THERAPY

In ovarian cancer, maintenance therapy should be a standard of care. Resources like the PQI on PARP Inhibitor Eligibility are imperative in identifying and appropriately offering efficacious treatments to eligible patients at the right time. Data presented at a European Society for Medical Oncology (ESMO) Conference showed that the majority of eligible patients were not on maintenance therapy⁹. A real-world data analysis by Garofalo and colleagues found that maintenance therapy was used in 49% of eligible patients, 47% of those on maintenance therapy received a PARP-I as the maintenance agent. Use of a PARP-I was higher in those with a BRCA mutation at 61%, vs 45% with wild-type or unknown status³. This study looked at maintenance after second line or greater therapy; newer data shows progression free survival (PFS) benefit of maintenance following first line therapy, highlighting the need to accurately identify patients upon initial presentation^{11,12}. Some studies on cost-effectiveness have demonstrated an increase in the cost when therapies other than PARP-I are utilized¹³. Further studies may provide additional insights into the role of comprehensive genomic profiling or the method of primary treatment and their impacts on treatment decisions and outcomes^{14,15}.

Tremendous opportunity for improving the rates of genetic testing and maintenance therapy exists; the problem is clear. With the combined clinical expertise of our partners and members, NCODA's PQI on PARP Inhibitor Eligibility and this PQI in Action initiative is the culmination of an idea into actualized patient care; it offers a standard solution for improving the delivery of care to ovarian cancer patients across six different organization and five different EMRs.



SOME DATA SUGGESTS THAT THE MAJORITY OF ELIGIBLE PATIENTS ARE NOT ON MAINTENANCE THERAPY.

POSITIVE QUALITY INTERVENTION

The NCODA PQI on PARP Inhibitor Eligibility provides awareness of the current deficits in ovarian cancer and encourages professionals to take a more proactive approach in improving current treatment standards. By providing specific strategies to identify, offer, and manage patients who would be eligible for maintenance therapy with a PARP-Inhibitor, more patients will receive and potentially benefit from the therapy. We will now examine and report on the experience of six leading oncology organizations and, thereby, demonstrate the need to ensure patients receive efficacious therapies for ovarian cancer.

Complimentary access to all NCODA PQI's available here:
www.ncoda.org/pqi



TANYA HIBLER, RN WITH FLORENCE OSISANYA, PHARM D

OVARIAN CANCER JOURNEY

Although the six partner organizations in this article each provide care to ovarian cancer patients in their own unique ways, commonalities exist. A consistent approach for all of them revolves around the MIP team involvement and the benefits that are inherent to the model. With multiple disciplines now playing an integral role in care, each respective member of the team should be working interdependently to achieve improved outcomes for the patients. Any team member may be handling critical aspects of ovarian cancer management including schedulers, assistants, administrators,

genetic counselors, nurses, pharmacists, and the provider. Accordingly, the PQI has inherent value for all members of the team in providing awareness to standardized, effective practices.

Indeed, working together, the team becomes stronger. To deliver excellent care to their patients, these six organizations have partnered with NCODA to provide collective value by creating and using a consistent resource: NCODA's PQI on PARP Inhibitor Eligibility.



PHARMACIST RALI ANGUELOVA, PHARM D COUNSELS A PATIENT ALONGSIDE ELIZABETH LINDQUIST, PHARM D

“SELECTION OF MAINTENANCE THERAPY ULTIMATELY COMES DOWN TO TREATING THE PATIENT AND NOT JUST THE DISEASE.”

BEGINNING OF THE JOURNEY

Typical ovarian cancer patient presentation may begin with a community obstetrician or a community medical oncologist where the condition is diagnosed. Patient workup usually involves referral and meeting with a Gynecologic Oncologist to assess patient characteristics, obtain imaging (CT scans), tumor and/or blood samples, determine staging, and create a treatment plan. Genetic testing is offered to patients at all six organizations (regardless if they have a genetic counselor on site or not) as a standard practice. Genetic alterations (BRCA 1 and 2, specifically) help to identify the most efficacious treatments and appropriate steps of therapy. Real world experience from St. Luke's Health System genetic counselor, Emily Fassi, MS, LCGC, shows that about 25% of eligible patients were not referred for genetic counseling.

Initially, patients may qualify for neoadjuvant chemotherapy plus interval debulking surgery (NACT+IDS), or, primary debulking surgery (PDS); the initial treatment decision may



AS LONG AS TUMOR MARKERS LIKE CA-125 AND HE4 ARE IMPROVING, THERE IS NO NEED FOR RE-SCANNING DURING INITIAL TREATMENT.

impact later outcomes in particular patient subsets¹⁵. Based on patient response after three cycles of a platinum-based chemotherapy regimen (often Carboplatin + Paclitaxel/Docetaxel), some providers reassess with imaging while others continue treatment and assess tumor markers. For example, Chief of Gynecologic Oncology for Southern Illinois University (SIU), Laurent Brard, MD, PhD, states, "As long as tumor markers like CA-125 and HE4 are improving, there is no need for re-scanning during initial treatment."

Following traditional initial treatment with six cycles of chemotherapy, there are ramifications around various treatment decisions. The following briefs are takeaways from each of the six organizations.



APRIL PARKER, CPHT AND LESLIE GIANG, PHARMD IN THE ON-SITE IV ADMIXTURE ROOM.

MAINTENANCE THERAPY

Once the patient has achieved an initial platinum-based regimen, the treatment path begins to split into many potential routes. Patients may be classified as non-responders, Platinum-Sensitive (recurrence was greater than six months following initial response), or Platinum-Resistant (recurrence less than six months), or may still be in response without detected recurrence.

In the maintenance setting for BRCA-mutated patients, all six organizations would consider use of a PARP-I. For example, medical oncologist at Swedish American Health, William Schulz, MD, said "I tend to use olaparib (Lynparza)." While niraparib (Zejula) and rucaparib (Rubraca) are both part of ongoing clinical studies in the first-line maintenance treatment setting before recurrence, an FDA-approved indication currently exists for olaparib¹⁶.

At Joliet Oncology & Hematology Associates, responsive patients will generally receive additional chemotherapy or IV treatments until recurrence, at which time they would be offered a PARP-I like niraparib. Upon recurrence, all organizations would similarly consider offering any of the PARP-I options, regardless of BRCA status. Additional PARP-I options that are FDA-indicated after recurrence include niraparib and rucaparib. Upon recurrence, all six organizations would consider genetic testing again, particularly if not done initially. Medical oncologist at Northwest Oncology & Hematology, Steven Kanter, MD, shared, “Previously we would test at recurrence but now all patients receive initial genetic testing.” Dr. Laurent Brard also seeks additional patient-specific characteristics through genetic testing beyond BRCA. He stated, “I will look into BRCA, TP53, CHEK2, RAD51, BRIP1, and PALB2 mutations; if any patients test positive for any of those mutations, they will likely receive a PARP-I.” Future treatments will likely be developed around these mutations and offer further options for patients¹⁷. To ensure patients are not overlooked for a maintenance therapy, organizations should adopt the standardized practices as described in NCODA’s PQI on PARP Inhibitor Eligibility.



LESLIE GIANG, PHARM.D AND MEGAN SHERRARD, RN,
DISCUSS A PATIENT IN THE AMBULATORY
CHEMOTHERAPY CLINIC

SELECTING A PARP-I

In the setting that PARP-I's are indicated, selection is largely based upon individual patient characteristics. Pharmacy Manager at Texas Oncology, Leslie Giang, PharmD, stated, “We primarily look at the side effect profile, potential patient tolerance, drug interactions, dosing schedules, degree of adherence, as well as insurance coverage for the PARP-I”. Some agents may cause elevated creatinine, transaminases, or myelosuppression and would be inappropriate for certain patients. Dr. Brard of SIU mentioned, “A patient with hypertension, for example, would not be an ideal candidate for Avastin (bevacizumab) and may benefit from a PARP-I instead.”

Similarly, medical oncologist of Texas Oncology, Sudha Teerdhala, MD, shared, “PARP-I treatment depends on if anemia is significant; if the patient's counts haven't recovered or cytopenic, it's hard to put them on full dose inhibitors if their numbers and labs don't look good.” Use of NCODA resources, such as the PQI on Niraparib: Dose Modification, can assist all members of the MIP team to make sophisticated recommendations for optimal dosing.



I WILL LOOK INTO TP53, CHEK2, RAD51, BRIP1, AND PALB2 MUTATIONS; IF ANY PATIENTS TEST POSITIVE FOR ANY OF THOSE MUTATIONS, THEY WILL LIKELY RECEIVE A PARP-I.

Complimentary Access to Niraparib PQI here:
www.ncoda.org/niraparib-dose-adjustment-based-on-weight-and-platelet-counts/

EMR CHARACTERISTICS & EFFECTIVE PRACTICES

Regimen	Medication order set including IV, administration/supportive, oral medications, often in combination (generally adopted from evidence-based guidelines)
Pathway	Decision-making tool to assist in the utilization of preferred therapy agents within an organization for a given patient case
Treatment Plan	Global assessment of patient and planned courses of therapy, often involves bundling of orders (such as appropriate labs and follow-up appointments created with one click of the mouse)

DEFINITION OF TERMS

Texas Oncology utilizes a unique EMR system that includes a decision-making and treatment-ordering tool. Dr. Sudha Teerdhala said, “Pathway options within this tool are aligned with NCCN guidelines and are clinically supported by evidence. All patient care is done through this one system with all levels and disciplines of care sharing the same interface, including diagnosis, staging, treatment decisions, supportive tests, imaging, and all related documentation. Additionally, as an active participator in the Oncology Care Model, Texas Oncology providers ensure eligible patients are presented with the choice to continue their care with the available options.” With a medically integrated and multidisciplinary approach, the entire team is well-positioned to deliver optimal, collaborative care. Maintenance options, including PARP-I, are prebuilt within the EMR. The pharmacist here serves as a source of drug information and education and is able to share the PQI principles with the entire multidisciplinary team.

Simmons Cancer Institute at Southern Illinois University (SIU) utilizes another EMR to manage unique patient experiences. Here, collaborative care occurs with rural community oncologists outside of SIU's main location in Springfield, IL. Referrals from community providers reach Gynecologic

[illegible]

EXAMPLE OF OVARIAN CANCER REGIMENS

Oncologist Laurent Brard, MD, PhD, who assists in determining the patient's potential for surgery and treatment options. The nursing and scheduling teams track patients and deliver excellent care together. Without oncology-specific focus, there are no set flags, tracking mechanisms, or prebuilt treatment regimens within this EMR system. Oftentimes, patients use their local treatment center for neoadjuvant or adjuvant chemotherapy regimens which are administered by a community oncologist. With varying EMR systems from each community partner, Dr. Brard offers a solution by following every patient via thorough treatment plans he creates and shares with his team. Additionally, SIU standard processes

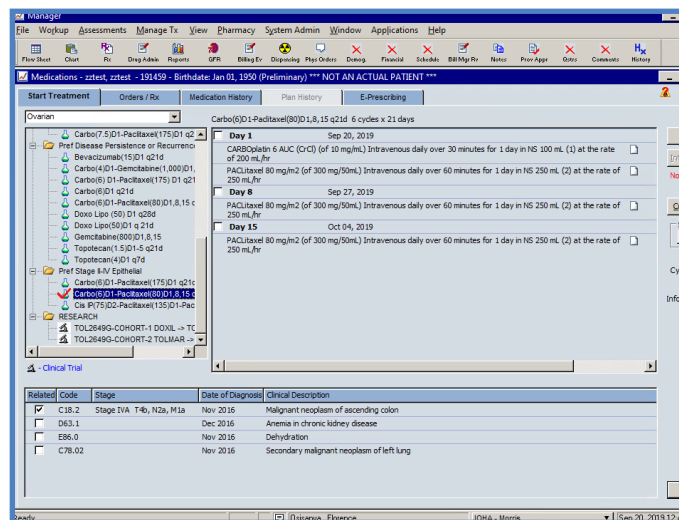
ensure at least a triple-check verification of orders between the prescriber, nursing, and pharmacy teams. SIU will be increasing multidisciplinary engagement by opening up their own internal pharmacy by the end of this year. Members of the team, like certified nurse practitioner Lorie Sporrer, FNP-BC, look forward to having dispensing capability on site. She said, “Having our own pharmacy in operation with clinical pharmacists playing an increasing role will help us all to improve patient care.” During his extensive experience, Dr. Brard said, “Options are always available for patients.” He continued, “Surveillance is a critical time for ovarian cancer patients.” NCODA recognizes and values the intimate relationships that exist between providers, patients, and the full team; SIU demonstrates a coordinated care effort over great distances in a rural community setting. The PQI on PARP Inhibitor Eligibility connects the various treatment settings and cancer care providers through one standardized, effective practice. The nurses here help disseminate the principles of the PQI with the rest of the team to ensure appropriate appointments and follow-ups are conducted.

Similarly, the delivery of care within a third EMR system ultimately relies on the individual staff members working together as demonstrated with Joliet Oncology & Hematology Associates in Illinois. Oncology Clinical Pharmacist Florence Osisanya, PharmD, said, “Full patient workup is shared in real time amongst all professional disciplines, including past histories of treatments and genetic testing results. Treatment regimens are built for ovarian cancer that reflect NCCN Guidelines.” Upon progression, these patients are strictly monitored not only by providers but also by nurses, pharmacists, and schedulers within that connected EMR. Nurses initiate adherence and check-in calls and the PQI informs them of appropriate tracking and timing around maintenance therapy. Again, utilizing the PQI on PARP Inhibitor Eligibility, the MIP team adopts standard principles within their organization. Here, the pharmacist and nurse disseminate the PQI principles to the rest of the team to track the timing of treatment milestones and ensure appropriate maintenance therapy.

“OPTIONS ARE ALWAYS AVAILABLE FOR PATIENTS... SURVEILLANCE IS A CRITICAL TIME.”

The medically integrated pharmacy team at Swedish American Hospital in Illinois is currently bringing value to patients by building and implementing oral treatment plans within a fourth EMR system that is commonly used in hospital systems.

Treatment regimens and plans are not standardized in the maintenance setting and they vary considerably among oncologists. Once in place, these treatment plans will allow prebuilt scheduling and tracking of treatment milestones including labs and follow-up appointments. During this transition, the clinical information contained within the NCODA Positive Quality Intervention documents enables the entire care team to deliver consistent practices. Oncology Pharmacist Ralitz Anguelova, PharmD, said, “Although we are not using clinical pathways at this time, we keep track of the patient’s progress in the EMR, which contains detailed treatment plan information.” Patient management software is also utilized to assist after an oral therapy is dispensed. Medical oncologist William Schulz, MD, explained that he works closely with other providers and the multidisciplinary team to deliver quality care. He added, “With no set flags within the EMR to prompt maintenance therapy in ovarian cancer patients, our teamwork and ability to exchange knowledge is imperative.” By sharing knowledge via the PQI and leaving detailed notes within the

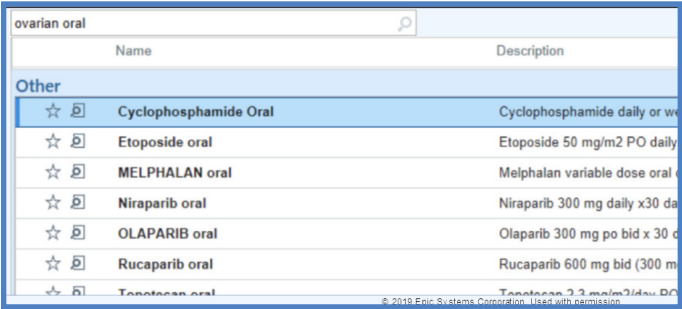


OVARIAN TREATMENTS OPTIONS IN AN EMR

treatment plan, pharmacists, nurses, and schedulers can follow-up with the patient at the appropriate critical time intervals. Another organization, St. Luke's Health System (Mountain States Tumor Institute) located in Boise, Idaho and across the Mountain West region, uses this same EMR to care for patients. Oncology Clinical Pharmacist, Stephanie Matta, PharmD, stated, “Whenever a new treatment agent or plan gets approved, one of the pharmacists involved with the EMR-build would create the plan and get other pharmacists to test it. The plan is published after it is approved by the EMR validation committee which includes pharmacists and physicians.” This effective practice for incorporating new regimens and plans into this

EMR increases the likelihood that an ovarian cancer patient receives an appropriate maintenance therapy.

Northwest Oncology & Hematology in Illinois also delivers coordinated care to their patients through the connectivity of the entire MIP team. Medical oncologist Steven Kanter, MD, stated, “Having a pharmacist in the practice is extremely beneficial.” An integral member of Dr. Kanter’s team is Clinical Pharmacy Manager Lisa Raff, PharmD, BCPS, BCOP. As an



Name	Description
Cyclophosphamide Oral	Cyclophosphamide daily or weekly
Etoposide oral	Etoposide 50 mg/m2 PO daily
MELPHALAN oral	Melphalan variable dose oral
Niraparib oral	Niraparib 300 mg daily x30 days
OLAPARIB oral	Olaparib 300 mg po bid x 30 days
Rucaparib oral	Rucaparib 600 mg bid (300 mg po bid)
Tazemetumab oral	Tazemetumab 3 mg/m2 PO daily

OVARIAN MAINTENANCE TREATMENTS OPTIONS IN ANOTHER EMR

PATIENT TRACKING VIA SCHEDULING AND FOLLOW-UP

This research at six leading oncology organizations with five different EMR systems has revealed that the mechanics of the individual EMR are not critical. Instead, patients benefit from improving the standard processes for personnel. By providing recommendations for effective processes, the PQI on PARP Inhibitor Eligibility ensures that a coordinated effort by the entire MIP team is the reliable standard. Although software systems differ from one organization to the next, a consistent effective practice among them is to ensure proper scheduling of patient follow-up through the shared EMR.

THIS MULTIDISCIPLINARY APPROACH TO SCHEDULING AND FOLLOW-UP WORKS WELL FOR US. WE CREATE REMINDERS IN THE EMR THAT ARE EFFECTIVE AND HAVE IMPROVED SAFETY.

The MIP team carefully marks the dates for treatment milestones including scans after initial chemotherapy, anticipated surgery, adjuvant chemotherapy, regular follow-up around three months or when the physician dictates. In keeping all details electronic within one system, scheduled appointments, scans, etc. can be viewed and tracked by all staff. Dr. Steven Kanter stated, “This multidisciplinary approach to scheduling and follow-up works well for us. We create reminders in the EMR that are effective and have improved safety.” Within a different setting, Clinical pharmacist Stephanie

active and engaged NCODA member, Lisa brings valuable peer-reviewed clinical information via the PQI to her colleagues.

HAVING A PHARMACIST IN THE PRACTICE IS EXTREMELY BENEFICIAL.

Without any prebuilt regimens within this fifth unique EMR system, the pharmacist has built all flow sheets and regimens for the organization. Both Lisa and Dr. Kanter advocate for referral to genetic counselors as a standard process. Further tracking is done via the EMR with all staff including scheduling. Having been an author for a PQI and also by serving on the PQI Review Committee, Lisa stays well-informed of the latest topics in oncology care. There is recognizable trust demonstrated by this intimate team. Undoubtedly, this integrated model and adoption of PQI principles has resulted in improved care for patients at Northwest Oncology & Hematology.

Matta, PharmD, stated, “When it comes to patients who are receiving PARP inhibitors, medical oncologists send the initial treatment plan and pharmacists create a list of personal reminders which are sent to the oral chemotherapy pharmacy team to track those patients.” For teams that provide care in concert with community oncologists in rural settings, manual tracking of patients, including those in surveillance, assures



STEPHANIE COLVIN, LISA SULLIVAN, RN AND FLORENCE OSISANYA, PHARM D DISCUSS THE PQI

appropriate therapy is offered. Effective triple-checking practices ensure all patients are seen one month following their last cycle. Again, these teams deliver consistent care to their patients by working together and utilizing the consistent processes described in the PQI.

CONCLUSIONS

The PQI on PARP Inhibitor Eligibility enables MIP teams to employ key principles to deliver quality care to ovarian cancer patients. By utilizing these effective practices, organizations can track and treat patients with an appropriate therapy at the appropriate time. One such PQI principle is to ensure all patients are referred to a genetic counselor for evaluation. Clinical, evidence-based EMR Pathways, Regimens, Treatment Plans, or Patient Management Software should be utilized when available. If PARP inhibitors are not currently built within the regimens or potential treatment options listed in the EMR, teams need to work with the vendor to ensure these options are included and not overlooked. Another effective process is scheduling appropriate timing of follow-up visits, imaging scans, and next lines of therapy following initial diagnosis and subsequent treatment (surgery/chemotherapy) within the EMR. Although systems differ from one organization to the next, a consistent effective practice among them is to ensure proper scheduling of patient follow-up through manual data entry within the medical record. Typical anticipated treatment milestones (such as final cycle of chemotherapy, surgery, and appropriate time to maintenance therapy) are manually tracked at all six organizations and serve as a critical patient safeguard. By building treatment plans with bundled order sets of labs and appointments, team efficiency is improved. Utilizing the PQI on PARP Inhibitor Eligibility, the entire MIP team consistently checks the EMR to ensure these appointments and calls are made accordingly.

While following up with patients during treatment, professionals have shared that patient education is another key factor. Effective practices include constant evaluation and reassessment of emesis, depression, and quality of life. Dr. Sudha Teerdhala stated, "Patient perception as to what is the standard of care (IV vs PO) or the 'best' way to be treated (IV > PO) can be a critical area for education and clarification. We also consider the emotional response to the perceived cost of therapy by the patient." Another key aspect is ensuring that the patient has confidence in the treatment and ability to improve quality of life.

Lastly, ovarian cancer care is best delivered by a multidisciplinary, medically integrated team; this is the model that enables professionals to achieve positive outcomes for patients. Utilization of consistent clinical information like that contained within NCODA's PQI standardizes knowledge

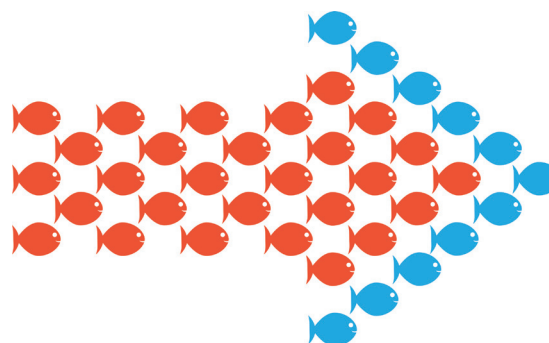
Key PQI Principles

- Genetic Counseling
- EMR Utilization (regimens, plans, scheduling)
- MIP Team (awareness, coordination)

exchange within an organization. Clinical pharmacists should play a proactive role in treatment decisions with the prescriber whenever possible. Nurse navigators are recommended not only for the more common cancers like breast but also ovarian and all other oncology patients. Genetic counselors, schedulers, pharmacists, providers, technicians, financial counselors, assistants, administrators, and more all play an integral role in the delivery of care. All members of the MIP team should be NCODA members to stay informed of the current NCODA PQIs and to disseminate the clinical PQI principles to their colleagues.

In closing, the Positive Quality Intervention tool has brought value to the medically integrated care teams at these six leading oncology organizations. The NCODA PQI in Action has collaborated with experts to create the PQI on PARP Inhibitor Eligibility and has assisted healthcare professionals to deliver higher quality care to their ovarian cancer patients. Through this medium, NCODA brings awareness to the fact that PQIs are publicly available on the website. Furthermore, NCODA recommends a wider adoption of new procedures to utilize clinical guidance information and employ the consistent principles contained within all PQI documents to help professionals to deliver improved outcomes for oncology patients.

Author: Matthew Schulz, PharmD



Working Together, We Become Stronger

REFERENCES

1. Randall LM, Aydin E, Louie-Gao M, Hazard S, Westin SN. A retrospective analysis of real-world tumor BRCA (tBRCA) testing trends in ovarian cancer before and after PARP inhibitor approvals. Presented at the 17th Biennial Meeting of the International Gynecologic Cancer Society; Kyoto, Japan: 2018.
2. Randall LM et al. Multi-disciplinary summit on genetics services for women with gynecologic cancers: A Society of Gynecologic Oncology White Paper. *Gynecol Oncol*. 2017;146:217-224.
3. Garofalo D, Verma-Kurvari S, Aydin E, et al. Real world data analysis of ovarian cancer maintenance utilization among maintenance eligible patients. Presented at the American Society of Clinical Oncology Annual Congress; Chicago, IL: 2019.
4. Randall LM, Birrer MJ, Herzog TJ. Ovarian cancer maintenance: practice-changing data calls for changing practice. *The Oncologist* 2019;24:1-4.
5. Childers CP, Childers KK, Maggard-Gibbons M, Macinko J. National estimates of genetic testing in women with a history of breast or ovarian cancer. *J Clin Oncol* 2017;35(34):3800-3806.
6. Francis S, Ager B, Do O, et al. Recurrent early stage endometrial cancer: Patterns of recurrence and results of salvage therapy. *Gynecologic Oncology* 2019; 154(1):38-44.
7. Buchanan TR, Griffin NE, Leon C, et al. Maintaining adherence rates for genetic testing in an era with fewer in-office counselors. *Gynecologic Oncology* 2019; 154(1):204.
8. Daly MB, Pilarski R, Berry M, et al. NCCN guidelines insights: Genetic/familial high-risk assessment: Breast and ovarian, version 3.2019. *J Natl Compr Canc Netw* 15:1-18-2019.
9. Mahner S. Proceedings of ESMO Educational Symposium. Presented October 22, 2018. Available at <https://cslide.ctimeetingtech.com/library/esmo/browse/search/262N#2Ea4M>. Accessed July 17, 2019.
10. Randall LM, Birrer MJ, Herzog TJ. Ovarian cancer maintenance: practice-changing data calls for changing practice. *The Oncologist* 2019;24:1-4.
11. Moore K, Colombo N, Scambia G, et al. Maintenance olaparib in patients with newly diagnosed advanced ovarian cancer. *N Engl J Med*. 2018;379(26):2495-2505. doi: 10.1056/NEJMoa1810858.
12. GSK announces positive headline results in Phase 3 PRIMA study of ZEJULA (niraparib) for patients with ovarian cancer in the first line maintenance setting [press release]. London, UK: GlaxoSmithKline plc; July 15, 2019. <https://bit.ly/2YTFO6h>. Accessed July 15, 2019.
13. A.Y. Liu, J.G. Cohen, C. Walsh, et al. A cost-effective analysis of three PARP inhibitor for maintenance therapy in platinum-sensitive recurrent ovarian cancer. *Gynecologic Oncology* 2019; 149(1):9.
14. Prendergast E., Holman L, Liu A, Comprehensive genomic profiling of recurrent endometrial cancer: Implications for selection of systemic therapy. *Gynecol Oncol*. September 2019;154:461-466.
15. Yuki H, Paulina C, Fuki S. et al. Does the method of primary treatment affect the rate of first recurrence in high-grade serious ovarian cancer? . *Gynecol Oncol*. September 2019;154.
16. Lynparza (olaparib) tablets [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals; July 2019.
17. Toss A, Tomasello C, Razzaboni E, Hereditary Ovarian Cancer, Not only BRCA 1 and 2 Genes. *Biomed Res Int*. 2015; 2015: 341723.

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