



# NCODA POSITIVE QUALITY INTERVENTION IN ACTION >>>>>

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**EXTOLLING THE BENEFITS OF IDENTIFYING  
POLYCYTHEMIA VERA PATIENTS AND  
MYELOFIBROSIS WITHIN MEDICALLY  
INTEGRATED DISPENSING PRACTICES**



National Community Oncology  
Dispensing Association, Inc.  
PASSION FOR PATIENTS

# NCODA POSITIVE QUALITY INTERVENTION IN ACTION >>>>>

## EXTOLLING THE BENEFITS OF IDENTIFYING POLYCYTHEMIA VERA PATIENTS AND MYELOFIBROSIS WITHIN MEDICALLY INTEGRATED DISPENSING PRACTICES

### INTRODUCTION

In effort to promote higher quality patient care the National Community Oncology Dispensing Association, Inc (NCODA) constructed the NCODA Positive Quality Intervention to provide healthcare providers with the support and enhanced education to improve the overall management of patients receiving oral oncolytics. The PQI fosters better care for patients through increased speed to therapy, reduced cost and hospitalization, and by improving persistence and adherence within medically integrated teams.

The PQI in Action incorporates opinions and experiences from a variety of adept participants such as those from both New England Cancer Specialists' (NECS) and Utah Cancer Specialists' (UCS) medically integrated teams. Both practices have successfully implemented Medically Integrated Dispensing (MID) as well as the use of positive quality interventions throughout their care teams to improve the treatment regimens of Polycythemia Vera and Myelofibrosis identified patients.

### THE PARTICIPANTS

#### UTAH CANCER SPECIALISTS



PRESCRIPTION SERVICES COORDINATOR  
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PHARMACIST  
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## DEFINING MEDICALLY INTEGRATED DISPENSING AND IMPLEMENTING THIS MODEL OF SERVICE

Medically Integrated Dispensing refers to the practice team who supports patients on oral therapies; regardless of the location (health system or community), or pharmacy, or physician dispensing model. New England Cancer Specialists and Utah Cancer Specialists both adopted this model of dispensing as well as the care team structure several years ago in preparation to better serve their patients.

With three locations throughout Maine, New England Cancer Specialists currently has one practice dispensing. Utah Cancer Specialists have nine locations throughout Utah with currently one practice dispensing as well.

When implementing the MID within the practices both sets of participants expressed some initial hurdles that had to be overcome for the model to work successfully for the betterment of patient care. Nurse supervisor, Dawn Whitten, mentioned that when first starting the dispensing service at New England Cancer Specialists it was a challenge for her and her team to know which patients could be sent to the pharmacy as well as the contracts, insurance, and educational hurdles that came with that. The team was ready to service patients at the practice but were unable to, initially, due to these hurdles. Whitten expressed that over time a work flow was created, and more patients were being serviced onsite. Today, all oral oncolytics prescriptions are sent directly to the pharmacy.

At Utah Cancer Specialists Neil Nebughr RPh, Director of Pharmaceutical Services, shared that UCS had a hard time at the beginning of implementing the MID due to there not being

a license in the state of Utah that would cover dispensing as a physician practice. Eventually an act was created that included Medically Integrated Dispensing under a physician dispensing model where UCS was then able to move forward with the implementation of the MID.

When a practice is in the beginning stages of moving to the MID model of service, Steven D'Amato, NECS Executive Director, recommends “fully staffing the program from the start. Embrace all agents, roll it out to the whole team and market with full dedication.”

Having the MID onsite has improved the engagement between staff and patients tremendously. Patients appreciate the convenience of being able to get their prescriptions before leaving their appointment as well as the close personal contact and relationships they can form with their care team. Compared to specialty pharmacies, the pharmacists and pharmacy technicians can call and email patients daily. Pharmacist Jeff Audet, RPh at NECS expressed his appreciation for the model and the value that it brings to their patients. “We are able to create a bond with the patient that makes them like family to us. We get to know our patients better by working together as a team. We go straight to the patient’s nurse or physician if needed to make sure we are all on the same page. There are a million examples I could share on the benefits that the MID brings to the patients. Everything is instantaneous. A patient may call the pharmacy feeling nauseous and we are able to go straight to their nurse, or physician if they are available to prescribe a treatment for the side effect.



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**WE ARE HERE FOR OUR PATIENTS TO PROVIDE QUALITY CARE. I FEEL GOOD ABOUT WHAT WE DO, AND WE HAVE CREATED A HIGHER STANDARD OF CARE AT NEW ENGLAND CANCER SPECIALISTS THROUGH MEDICALLY INTEGRATED DISPENSING AND OUR CARE TEAMS.**



PHARMACIST

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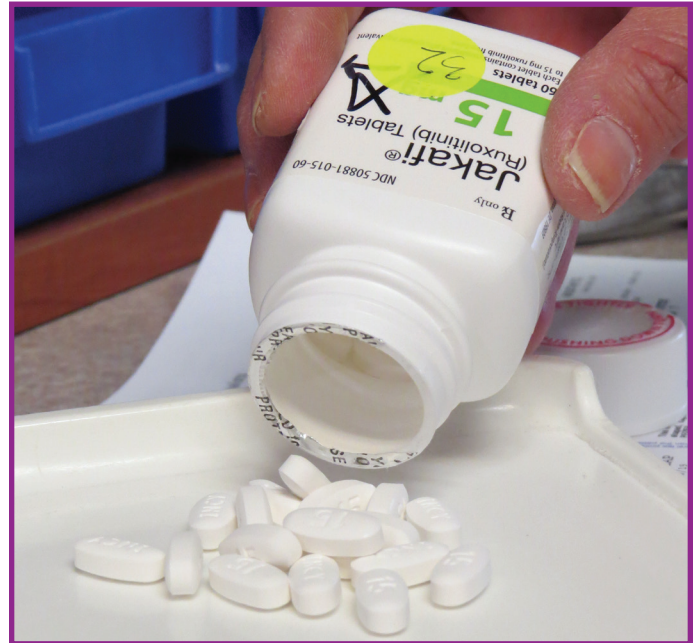


## HOW MEDICALLY INTEGRATED DISPENSING AFFECTS THE USE OF CO-PAY CARDS

The Medically Integrated Dispensing model allows practices to maximize the use of co-pay cards, when possible, with a decrease in patient out of pocket cost being the number one goal. At NECS if there is any out of pocket cost to the patient the pharmacist will then utilize a co-pay card if applicable. For commercial plans, the pharmacists at NECS typically utilize manufacture vouchers and, in a situation where that is not possible, the NECS Financial Advocates at the practice will research to find the appropriate grant or foundation to best help with this patient's out of pocket cost. NECS Pharmacist, Jeff Audet, RPh explains a firsthand situation that occurred within their dispensing practice. "We had a patient that was no longer going to take their recommended dose of Jackfi because this patient was on Tri-Care and their co-pay increased from three dollars to 28 dollars for the prescription. We were made aware of the situation from an adherence call between our care team and the patient. Once we were aware and unable to find a co-pay assistance at the time to relieve some of the stress of the additional cost to the patient, we then decided the practice would absorb the cost of the prescription to allow our patient to continue the care they needed. This patient would have not received this level of care from a payer/PBM mandated mail order pharmacy and they would not be receiving their treatment. It is not about money, it is about helping people." Utah Cancer Specialists has put in place very robust procedures to utilize co-pay systems from manufactures as well as finding assistance for free drug when needed.

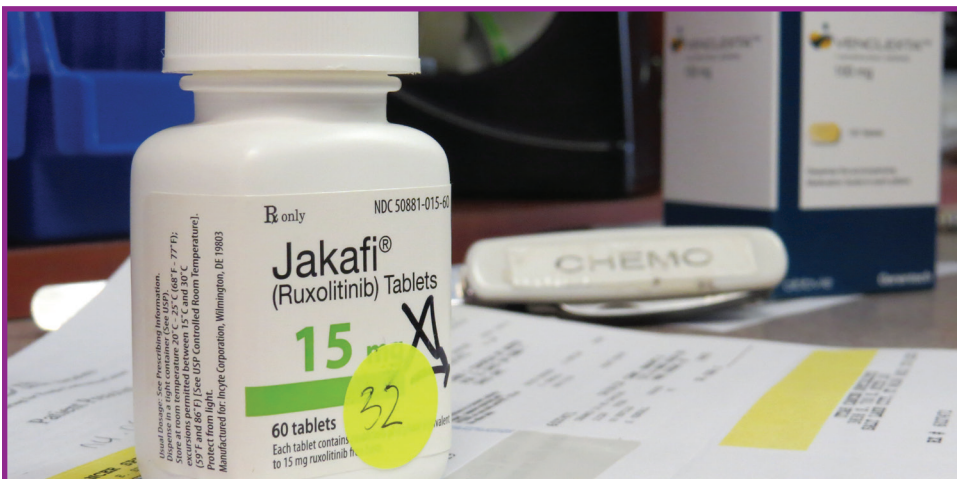
"Utah Cancer Specialist averages over \$100,000 a month in

savings for UCS patients by our team accessing co-pay assistance programs. Patients are reluctant to pay a co-pay of 50 dollars and if it cuts into their adherence or they refuse their treatment that is when we step in as a care team. Our staff will find assistance or see if they qualify for free drug from the manufacture.



As a last resort, we will then go back directly to the physician for an alternative therapy or treatment which only occurs less than one percent of the time at UCS but when it is one, it is too many."

- Neil Nebughr RPh, UCS Director of Pharmaceutical Services.



**“ IT IS NOT ABOUT MONEY, IT IS ABOUT HELPING PEOPLE.**

## MEDICALLY INTEGRATED TEAMS HELPING PROVIDE BETTER CARE FOR PATIENTS

The Medically Integrated Dispensing model allows pharmacy technicians at UCS to spend a large amount of their day making adherence phone calls to their patients. At UCS, a patient is contacted within 72 hours of their appointment, again after the first week and then routinely for refills. Both UCS and NECS's care teams try to sync patient follow up calls with their physician appointments. This allows for the pharmacies to ensure the drug being prescribed is in stock as well as how the patient is doing prior to the appointment. Staff typically structures the calls to ask open ended questions, thereby maximizing the amount of beneficial information they receive from the patient. "We try to keep our questions open ended such as "Tell me about any rashes you may have? Explain to me any sore spots, anything that looks out of the ordinary? What about diarrhea?" Asking questions like these allows us to know if there are any side effects occurring that the team needs to be aware of. We also are looking at the patient's labs, charts, last visit prior to the call and then following up with their nurse and doctor prior to their next appointment." Jeff Audet, RPh.

The MID model allows for open communication between a patient's care team. That includes not only physicians but: physician assistants, nurse practitioners, nurses, patient care coordinators, financial advocates, pharmacists, pharmacy technicians, and any others that may be assisting in providing the patient better care. For example, there is a great ease of being able to contact a patient's physician if the nurse, pharmacist, or pharmacy technician learns of adverse effects like dizziness or bruising occurring with a patient diagnosed with polycythemia vera that is taking Ruxolitinib (Jakafi) from an adherence call. At that time the team member can quickly update the EMR to put a note in the patient's chart and notify the physician directly.

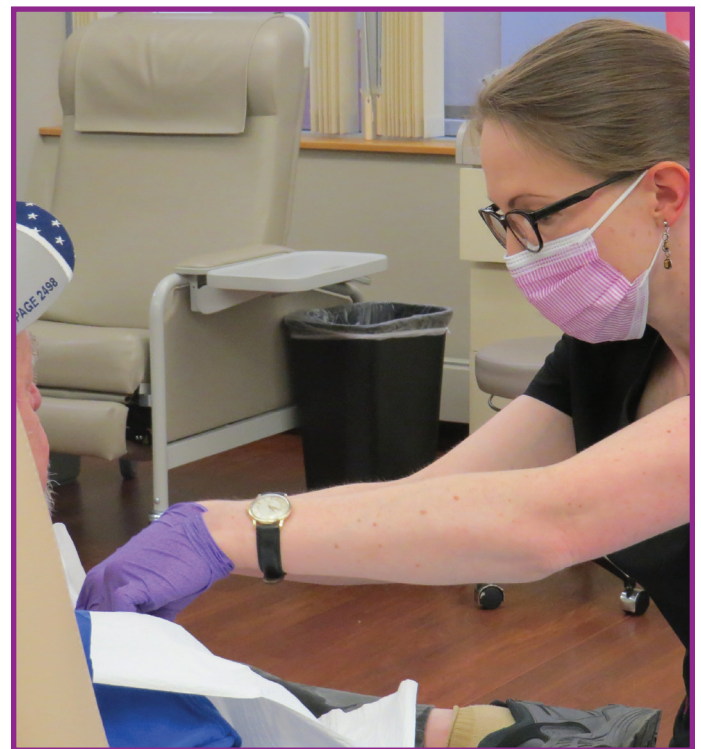
Prescription Services Coordinator, Danielle Ercanbrack CPhT at Utah Cancer Specialists explains why the communication between their medically integrated team helps provide better care for their patients. "At the beginning of implementing the MID model we didn't want to step on toes when talking to a physician regarding a patient's treatment regimen or potential changes in their dose, but it is not a personal thing. The patient is the number one person in the equation. We make sure the patient has everything they need and become more of a friend to them. We are not double checking the doctor's ability to do

their job, just making sure everyone is doing their part for the betterment of our patients."



### THE PATIENT IS THE NUMBER ONE PERSON IN THE EQUATION.

Dr. John Winters, MD from NECS elaborates on how utilizing a MID model creates efficiency within their practice, "The MID model makes it easier to switch therapies when needed. If a patient is experiencing a side effect of Jakafi, or other drug, then if needed I am able to stop his or her prescription while they are still in the clinic that day. Our pharmacists will not dispense the previous drug prescribed and will be notified immediately to dispense the alternative therapy at that time. Decisions are made in real time when seeing my patients which allows for the patient to receive basically all their care here. They leave that day with their new treatment regimen and either new drug or modified dose prescription in hand."



# IMPLEMENTING POSITIVE QUALITY INTERVENTIONS IN PRACTICES

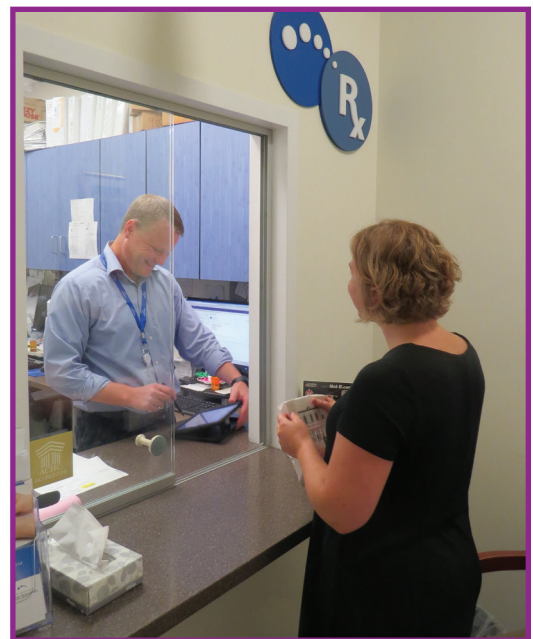
Care teams from New England Cancer Specialists and Utah Cancer Specialists have been able to utilize the NCODA Positive Quality Interventions easier by practicing within a Medically Integrated Dispensing model.

Danielle Ercanbrack CPhT shared how utilizing the PQIs within UCS has benefited their patients, “PQIs have become a resource that we use daily within our medically integrated team. All of our pharmacy technicians have the PQIs bookmarked on our internet browsers for quick access. If we receive a prescription with a high alert of a side effect of diarrhea, dry skin or mouth then we can then access the corresponding PQI for that drug and communicate directly with the oncologists to prescribe a recommended medication to ease those side effects. We then include the secondary prescription with the patient’s original prescription. If the PQI recommends pairing a cream with a drug then we make a note for new start patients to also include the cream with their prescription, at no charge, and we make the patient aware upon picking up their prescription. Our patients appreciate this extra level of service that we are able to provide from utilizing PQIs.”

Ercanbrack also explains how utilizing the Positive Quality Interventions has also changed their EMR procedures across the MID team. “The PQIs have taught us that if a patient is prescribed

a particular drug then they could also need a secondary drug as well to maximize their therapy. We are now all trained and have memorized these specific drugs because when we see these drugs mentioned in a PQI we make reminders for the next time we fill one of the included drugs. When we do dispense a prescription with a corresponding drug recommended we will then contact their doctor at that point to recommend the other drug as well for them to prescribe. We then note this in the EMR. This way their doctor will see the notation on the next appointment and will automatically prescribe both drugs.”

**“OUR PATIENTS APPRECIATE THIS EXTRA LEVEL OF SERVICE THAT WE ARE ABLE TO PROVIDE FROM UTILIZING PQIS.”**





# UTILIZING PQIS: MANAGING TREATMENT OF POLYCYTHEMIA VERA AND MANAGING MYELOFIBROSIS PATIENTS

## PQI DESCRIPTION AND BACKGROUNDS

PQI	DESCRIPTION	BACKGROUND
Managing Treatment of Polycythemia Vera (PCV)	Treatment of Polycythemia Vera can be challenging and identifying patients that are having a proper response to treatment is essential to preventing cardiovascular events. Establishing follow ups and lab reviews are recommended to ensure positive outcomes.	PCV is a primary polycythemia in which the bone marrow produces too many red blood cells, white blood cells, and platelets. An acquired mutation in the janus activating kinase 2 (JAK2), found in most PCV patients, allows these cells to proliferate leading to the abnormally high red blood count. Common treatments for PCV are aspirin, phlebotomy, hydroxyurea, interferon (not commonly used), or JAK2 inhibitor, Ruxolitinib. Hydroxyurea (HU) is considered the gold standard treatment to start with for high risk patients. Patients that are taking hydroxyurea and still have high blood counts or cannot tolerate it may benefit with treatment with Ruxolitinib.
Managing Myelofibrosis Patients	Jakafi (Ruxolitinib) is a selective JAK2 inhibitor used for the treatment of myelofibrosis (MF). It is a drug that requires close monitoring of platelets to ensure that a patient is on the appropriate dose and avoids severe thrombocytopenia due to the therapy.	Ruxolitinib is FDA approved for the treatment of intermediate or high-risk patients with myelofibrosis. A retrospective study of 108 patients (25 of which had low risk MF) showed patients who had moderate or severe splenomegaly reduced from 64% to 16% and moderate or severe fatigue reduced from 90% to 37% from diagnosis to time to best response with Ruxolitinib. This led to a category 2A recommendation in patients with low-risk, symptomatic MF.

## HOW PQIS ARE BEING UTILIZED WITHIN THE PRACTICE

The participants explained that the PQIs are used in various ways throughout the practice. For instance, at UCS the pharmacy technicians are making the documents easy to access when filling prescriptions to reference. Technicians are also printing the actual PQI off as a resource document for the patient to take with them and refer back to. "The patients are more aware of what could be normal or something that needs to be brought to our attention versus experiencing a side effect and thinking it is normal or doesn't need to be worried about, where the PQI is an excellent resource for the patient," states Tina McCallum RN, Nurse Manager at UCS.

Oncologist Dr. Wayne Orsmy, MD of UCS plans to implement the PQIs in his daily practice by using them as an educational resource while doing consultations with his patients. "Printing them out and highlighting aspects while including written notes as I go through it with the patient, the patient then can look

through it once they are home and can note questions to discuss at their follow up appointment.



## MANAGING TREATMENT OF POLYCYTHEMIA VERA PQI IN ACTION

When both Wayne Ormsby MD of UCS and John Winters MD of NECS see a patient they both practice similar with regards to reviewing the patient's chart and history prior to identifying a polycythemia vera diagnosed patient. Dr. Winters states that when he evaluates a new patient and they come in with a high red blood cell count alerting him to PCV then he typically makes the diagnoses by referencing the World Health Organization's diagnostic criteria. He then follows up with them frequently within the first 2 to 4 weeks until they are controlled. Dr. Winters utilizes the European Leukemia Network guidelines for response criteria to determine if the patient is responding, failing, or if the therapy needs to be switched.

### DETERMINING A LOW RISK OR HIGH RISK PCV PATIENT

#### LOW RISK PCV PATIENT CHARACTERISTICS:

AGE < 60 AND NO PREVIOUS HISTORY OF BLOOD CLOTS

#### HIGH RISK PCV PATIENT CHARACTERISTICS:

AGE > 60 OR PREVIOUS HISTORY OF BLOOD CLOTS

## LAB MONITORING FOR PCV PATIENTS TAKING HYDROXYUREA AND RUXOLITINIB

Dr. John Winters MD will monitor his patient's HGB and HCT counts every three months if the patient is considered stable but will not wait longer than three months. If a patient is just starting Ruxolitinib (Jakafi) then he monitors them every two weeks and for a non-stable patient he monitors at least once a month if not more, making dose and drug adjustments as needed until a patient is stabilized. Dr. Winter addressed the ease and effectiveness of the MID model, mentioning that he recently changed the dose for Jakafi with two patients during their visit and both were dispensed the correct dose before they left the practice that same day.

Whereas Dr. Wayne Ormsby also monitors newly diagnosed, or unstable, patients weekly for typically the first 6 weeks or until needed, monitoring their CBC while making dose adjustments as needed. He monitors patients considered stable (when their HCT stays below 45%), for three months or longer.

Both doctors expressed that the convenience of having their lab on site at the practice allows them to monitor lab results quickly and efficiently prior to making any dose adjustments. Both physicians are able to receive lab results as soon as five minutes after they are taken.

Nurse Manager at UCS, Tina McCallum RN, states that she is able to use the two MF & PCV PQIs when drawing labs on patients specifically to Hydroxyurea (Hydrea). "The use of the PQIs allows

myself and our clinical team the resource to better care for patients. For instance, if there is a patient on Hydrea I am able to watch their blood counts and quickly utilize the PQI as a reference. If Hydrea is not effective for the patient, then at that time I see if the patient meets the criteria to change to another drug. Depending on what the patient's counts are, we alert the physician as well provide a recommendation for a change in drug if criteria is met. For example; The patient's H&H is still elevated, should we switch their treatment from Hydrea to Jakafi? Allowing us to better service the patient but also as an additional resource to the team.





## DOSE ADJUSTMENTS FOR HYDROXYUREA AND RUXOLITINIB

When a patient is either not responding to their original therapy or are experiencing side effects from Hydroxyurea (Hydrea) or Ruxolitinib (Jakafi) dose adjustments can be made immediately. Physicians noted that typically with prescribing Hydroxyurea the prescription is ready almost always that same day or the next. Like most oral therapies prescribed in clinical settings, financial toxicity to the patient can delay treatment. Investigating co-pay and foundation assistance is critical to enhance the speed to therapy. This further emphasizes the importance of having an MID team solely focused providing value to oncology patients.

When making a dose adjustment for Hydroxyurea or Ruxolitinib it is typically due to a patient experiencing severe side effect and intolerance or the prescribing physician discontinuing the drug. Dr. John Winters MD and Dr. Wayne Ormsby MD have identified PCV or MF patients that have benefited from dose adjustments or treatment regimen modifications and have discussed those changes below.



### POSITIVE QUALITY INTERVENTION Q&A

#### QUESTION:

When identifying polycythemia vera or myelofibrosis patients that may benefit from dose or treatment adjustments, what causes you to make a modification?

#### ANSWER:

Dr. Ormsby: "When a patient is intolerant and experiencing side effects or the disease is not responding I then proceed with an adjustment."

Dr. Winters: "When monitoring a patient's baseline platelet count or treatment goals I will know if I need to make appropriate therapy changes."

#### QUESTION:

What adjustments to their therapy did you recommend?

#### ANSWER:

Dr. Ormsby: "When I have a patient who is experiencing side effects not allowing them to receive a higher dose of Hydrea or to allow them to continue on Hydrea, I will then switch them to Jakafi. With PCV patients I typically start them on Hydrea and Jakafi is reserved for an intolerant or adverse response. Sometimes I will begin a PCV patient on Jakafi as a first line therapy based on risk."

Dr. Winters: "Recently I had one PCV patient on Hydrea who's HCT was at goal, but their platelet count was not. After monitoring their baseline platelet count for a period I then switched their treatment from Hydrea to Jakafi. The second patient was identified with myelofibrosis and was taking Jakafi but was continually not at goal. I then decreased their Jakafi dose to 10mg in the morning and to 5mg at night. Before they were taking 10mg twice a day."

#### QUESTION:

How did the patient respond to the changes made?

#### ANSWER:

Dr. Ormsby: "Most of my patients do well when making adjustments to Hydrea or Jakafi. Especially on Jakafi, most tolerate it very well and that is what I like about prescribing it."

Dr. Winters: "These changes were just recently made so I can't officially say how they have responded just yet. Responses vary depending on the patient, but I am constantly adjusting therapy as needed. With the MF patient, I have made various changes before this most recent dose change. I typically make changes every three months depending on what the situation is."



HEMATOLOGIST/ONCOLOGIST  
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HEMATOLOGIST/ONCOLOGIST  
**JOHN PAUL WINTERS III, MD**

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## FILLING HYDROXYUREA AND RUXOLITINIB WITH PAYER & PBM MANDATED MAIL ORDER PHARMACIES

Due to payer and pharmacy benefit manager mandates, practices are often able to fill a patient's Hydrea but unable to fill their Jakafi prescription. This causes not only confusion and a huge inconvenience for the patient but typically a delay in therapy. If the prescription must be filled and dispensed through a payer/PBM mandated pharmacy on average the patient will wait at least five days to receive their prescription but can also be delayed weeks. Patients are often put into situations where they can have one of their prescriptions filled at the practice and then receive their second prescription being filled by the payer PBM mail order pharmacies.

Urgent prescriptions are filled within a practice in less than two hours, whereas with a PBM 'urgent' is considered within two weeks which can significantly delay therapy.

Pharmacy Technician, Danielle Ercanbrack CPhT, shares about a patient she helped at UCS to receive their prescription despite mandates, "I recently had a patient that we were able to fill one of their prescriptions but not the other due to payer prior authorization constraints. It was a Friday evening and our practice had since closed while I was helping this patient. Due to it being the weekend the patient was going to have a long delay in starting their therapy since they needed both drugs. Thankfully, in this situation, I was able to work with the patient's insurance company to reason with them and to receive an override to fill the second prescription immediately within the practice. I was then able to reach the patient's prescribing

physician, despite it being after hours, to modify the dose to allow me to fill it. I was then able to fill the patient's prescription before they left that evening and there was not the delay in therapy that we were initially concerned about."

If the practice's pharmacy does not either receive prior authorization or mandates prevent from filling the prescription or continuing to do so after the first fill, then this causes frustration for the patient. Patients have expressed their lack of trust with working with payer/PBM mandated mail order pharmacies to Pharmacist, Eric Dallara RPh at NECS. "Our patient's biggest complaints when being forced to work with a payer/PBM mandated mail order pharmacy is the lack of personal service, urgency and inconvenience. There isn't a pharmacist for them to talk to or their chart for them to reference. They are skeptical about giving out their financials to just "anyone" and are very cautious and afraid of being scammed. And even worse if their prescription is mail ordered then they must make themselves available to sign for it when it arrives forcing them to have to take off work a lot of the times. There isn't the standard of care with payer/PBM mandated mail order pharmacies that we are able to provide at New England Cancer Specialists for our patients. We have captured a lot of feedback comparing our level of service to these outside mail order pharmacies utilizing the NCODA patient satisfaction survey. Our patient survey results are close to 100% approval rating versus outside mail order pharmacies."



**“ THERE ISN'T THE STANDARD OF CARE WITH PAYER/PBM MANDATED MAIL ORDER PHARMACIES THAT WE ARE ABLE TO PROVIDE AT NEW ENGLAND CANCER SPECIALISTS FOR OUR PATIENTS.**

## HELPFUL ASPECTS OF THE PQIS FOR CARE TEAMS



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**THE BIGGEST VALUE OF THE PQIS IS THEY STANDARDIZE WHAT WE ARE DOING.**



PHARMACIST

**JEFF AUDET, RPH**

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**PQIS ARE A GREAT RESOURCE FOR WHEN TALKING WITH PATIENTS FOR SIDE EFFECTS AND DOSE ADJUSTMENT RECOMMENDATIONS.**



PRESCRIPTION SERVICES COORDINATOR

**DANIELLE ERCANBRACK, CPHT**

Utah Cancer Specialists | Salt Lake City, Utah



**THE BROAD BULLET POINTS. I LOVE THAT THE PQI IS SUMMARIZED TO WHAT YOU NEED TO KNOW TO MAKE THE CARE THE BEST IT CAN BE FOR THE PATIENT. WHEN WE NEED QUICK ANSWERS, THE PQI IS EASY TO ACCESS AND NAVIGATE.**



DIRECTOR, PHARMACEUTICAL SERVICES

**NEIL NEBUGHR, RPH**

Utah Cancer Specialists | Salt Lake City, Utah



**PQIS ARE AN ASSET TO UTAH CANCER SPECIALISTS AS THEY ARE CONTINUALLY HELPING EDUCATE STAFF IN OUR MEDICALLY INTEGRATED PRACTICE. THEY HELP WITH THE TECHNICIANS BEING AWARE OF SIDE EFFECTS FOR VARIOUS DRUGS AND HELP SERVE AS SUPPORT FOR THEM TO BETTER ANSWER THE PATIENT'S QUESTION OR TO KNOW WHEN TO REACH OUT TO THE NURSE OR PHYSICIAN TO HELP ANSWER SUPPORTIVE CARE QUESTIONS.**



NURSE MANAGER

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Utah Cancer Specialists | Salt Lake City, Utah



**PQIS WILL IMPROVE SYSTEM MANAGEMENT AT UTAH CANCER SPECIALISTS.**



EXECUTIVE DIRECTOR

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**IMPLEMENTING THE UTILIZATION OF THE PQIS WITHIN OUR MEDICALLY INTEGRATED DISPENSING TEAM IS AN ADDED RESOURCE THAT ALLOWS THE PHARMACISTS TO PROVIDE A BETTER COMPREHENSIVE SERVICE TO OUR PATIENTS AT NEW ENGLAND CANCER SPECIALISTS.**

### IMPORTANT NOTICE:

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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