



DISPENSING PHARMACY:
*A VALUE PROPOSITION FOR
ONCOLOGY PRACTICES*



A special thanks to the ACCC Advisory Committee

Jan Merriman, RPh, BCOP

Director of Clinical and Pharmacy Services

Minnesota Oncology Hematology

Jennifer O'Shaughnessey

Contract Specialist & Oral Dispense Coordinator

Fort Wayne Medical Oncology and Hematology

Ruth A. Settle, RN, OCN

Practice Manager

Tri-County Hematology Oncology Associates

Michael Reff, RPh, MBA

Manager, The Patient Rx Center

Hematology-Oncology Associates of CNY

Greg Sieg

Dispensing Manager

Iowa Cancer Specialists

Michelle Taymuree, PharmD, MBA

Director of Pharmacy

Diablo Valley Oncology & Hematology

About The Association of Community Cancer Centers

The Association of Community Cancer Centers (ACCC) is the leading advocacy and education organization for the multidisciplinary cancer care team. Approximately 20,000 cancer care professionals from 2,000 hospitals and practices nationwide are affiliated with ACCC. Providing a national forum for addressing issues that affect community cancer programs, ACCC is recognized as the premier provider of resources for the entire oncology care team. Our members include medical and radiation oncologists, surgeons, cancer program administrators and medical directors, senior hospital executives, practice managers, pharmacists, oncology nurses, radiation therapists, social workers, and cancer program data managers. Not a member? Join today at acc-cancer.org/membership or email: membership@acc-cancer.org. For more information, visit the ACCC website at acc-cancer.org. Follow us on Facebook, Twitter, LinkedIn, and read our blog, ACCCBuzz.

©2015. Association of Community Cancer Centers. All rights reserved. No part of this publication may be reproduced or transmitted in any form or by any means without written permission.

Dispensing Pharmacy: *A Value Proposition for Oncology Practices*

{ An Evolving Marketplace }

In the last decade or so, a large number of oral oncolytics have been brought to market. These self-administered anti-cancer drugs offer both opportunities and challenges to oncology practices. Providers have seen a benefit to dispensing these medications directly to their patients as it allows them an opportunity to deliver critical education—potentially improving the quality of care they are providing. Physician dispensing also has the potential to lower the cost of care, bringing added value to both patients and payers. Further, after years of declining reimbursement, physician dispensing was initially seen as a potential new revenue source. At the same time, oncology practices looking to implement physician dispensing continue to face challenges and barriers, including: the high cost of the oral agents; restrictions about which drugs providers can, in fact, dispense; and increased competition from specialty pharmacies, which threatens a practice's ability to dispense long-term as some patients may be forced into using a specialty pharmacy to fill prescriptions.

{ How ACCC Can Help }

In 2011, the Association of Community Cancer Centers (ACCC) launched a major education initiative around physician dispensing pharmacies. The results were a series of tools that practices could use to make an informed decision about whether opening an in-office dispensing pharmacy was practical in their given setting.

More recently, the changing landscape of physician dispensing required ACCC to revisit the issue and focus on creating tools to support oncology practices that have dispensing pharmacies in place. This education project identifies barriers to successful dispensing and offers potential solutions to overcoming some of these barriers, including the following resources:

- A tool providers can use to educate patients about how they can partner with physicians to improve their care and treatment while on oral anti-cancer agents. ACCC's patient education tool (found on pages 11-13) can help oncology practices meet state laws that require dispensing physicians to alert their patients about other options to fill their prescriptions.
- An online tool to help oncology practices integrate data from their EHR (electronic health record) and pharmacy management software (PMS) systems to generate metrics on the quality of their dispensing services.

Additionally, this publication identifies barriers to physician dispensing, as well as strategies for overcoming these barriers, and communicating the value proposition to payers and drug manufacturers.

{ Restrictions to Physician Dispensing }

Some restrictions to physician dispensing are legal or regulatory in origin, deriving from state laws or policies established by the U.S. Food and Drug Administration (FDA). While almost all states allow for physician dispensing, some place limits on the types of dispensing allowed—most notably by restricting refills. Similarly, the FDA, when approving a drug that it considers particularly toxic to patients, can impose conditions for dispensing that oncology practices might be challenged to meet. Of the 18 oral oncolytics approved since 2011, the FDA has mandated Risk Evaluation and Mitigation Strategies (REMS) for four. However, given that these legal and regulatory barriers are not overly prevalent, they do not help to explain the large discrepancy between the number of oral oncolytics prescribed to cancer patients and the number of oncology practices that dispense.

Table 1. DISPENSING PATTERNS FOR ORAL ONCOLYTICS*

Drug	Percent of ACCC Member Practices That:		
	Dispense the Drug	Do Not Dispense	
		Would Be Interested in Dispensing the Drug	Have No Interest in Dispensing the Drug
Bosulif®	56%	33%	11%
Caprelsa®	11%	56%	33%
Cometriq®	6%	61%	33%
Gilotrif®	50%	33%	17%
Iclusig®	33%	44%	22%
Imbruvica®	61%	22%	17%
Inlyta®	56%	22%	22%
Jakafi®	67%	22%	11%
Mekinist®	39%	33%	28%
Pomalyst®	50%	28%	22%
Stivarga®	67%	22%	6%
Tafinlar®	44%	39%	17%
Xalkori®	61%	22%	17%
Xtandi®	83%	11%	6%
Zelboraf®	61%	22%	17%
Zydelig®	33%	44%	11%
Zykadia®	17%	61%	22%
Zytiga®	78%	22%	0%

*Data derived from a 2015 survey of ACCC member practices that dispense oral drugs. 31 practices responded; 18 of which provided the data used in the table.

In 2015, ACCC surveyed its members about physician dispensing and found that all responding oncology practices reported at least one drug that they would like to dispense but could not. Table 1, left, lists a number of oral oncolytics commonly used to treat cancer, if the responding oncology practice currently dispenses the drug, and whether or not the responding oncology practice would like to do so in the future. The ACCC survey also revealed that the presence of a REMS seemed to have a dampening effect on physician dispensing patterns. On average, about half of respondents dispensed drugs that did not require a REMS, while only one-third of responding practices reported that they dispensed a drug with a REMS.

Many industry experts believe the low percentage of dispensing oncology practices can be at least partly attributed to the increased number and use of specialty pharmacies. To understand how specialty pharmacies may impact physician dispensing, it is useful to briefly review how they came to be, the services they provide, and how those services meet the needs of both payers and drug manufacturers.

{ The Rise of Specialty Pharmacy }

The origins of specialty pharmacy can be traced back to an era when prescription medications were relatively inexpensive and their use was so straightforward that health insurers, which had expanded their coverage throughout the 1960s to include a pharmacy benefit, did not have to address them. (By 1970 prescriptions represented 40 percent of all healthcare claims, but less than 5 percent of healthcare expenditures.¹) Overwhelmed with low-value, high-volume claims that were costing payers more to process than to pay out, health insurers turned to a new type of company—pharmacy benefits managers (PBMs)—for help. PBMs could process large numbers of uncomplicated claims and make a profit—while still charging payers less than what it cost them to do the job. Ever since that time, PBMs have acted as a middleman between payers, manufacturers, patients, and dispensers.

In the years that followed, PBMs used their market power to reduce dispensing costs by creating pharmacy networks; PBMs were also able to reduce what they—or their health insurer clients—paid for drugs through the use of generics or “the threat of generic use” to drive down costs. However, the advent of orphan drugs in the 1980s and the biologics revolution that gained momentum the following decade presented PBMs with a series of challenges:

- Retail pharmacies, whose operations were structured to optimize the dispensing of drugs used to treat high-volume conditions (e.g., infection, pain, gastrointestinal distress), could not efficiently dispense drugs that were needed by only one or two of their customers.
- Retail pharmacies also had little experience with products that required special handling, had complex dosing schedules, and were often prescribed to patients with multiple co-morbidities—characteristics that were typical of many anti-cancer biologics.

- The strategy of relying on generic competition to drive down acquisition costs became obsolete as orphan drugs rarely had any generic equivalents.
- These new anti-cancer drugs came with higher costs. Because these agents were more complex to manufacture and—in the case of agents with orphan drug designation—were treating patient pools of thousands rather than millions, the per unit costs for the new classes of drugs increased dramatically. These costs were problematic for PBMs whose success was dependent on demonstrating cost-savings to their health insurer clients.

By the 1990s these marketplace factors forced PBMs to adopt a new business model, expanding their model from one that focused solely on efficient processing of high-volume, low-cost, routine transactions to one that included overseeing the distribution and use of very expensive, complex drugs to limited numbers of patients. Much as their health insurance clients had looked to PBMs 20 to 30 years prior, PBMs looked to a new type of organization—the specialty pharmacy—to help them transition to this new business model.

Table 2. SPECIALTY DRUG CRITERIA & SPECIALTY PHARMACY SERVICES

Criteria for Specialty Drugs	Services Provided by Specialty Pharmacies	Specialty Pharmacy Service Objectives
<ul style="list-style-type: none"> • High-cost • High likelihood of adverse event in patients • Complex dosing requirements that may be challenging for patient adherence • Drugs that require substantial patient education • Drugs that are used for complex and/or chronic conditions • Drugs with special handling requirements 	Benefits assessment	Ensure appropriate patient access
	Help identifying sources of financial assistance	Ensure appropriate patient access
	Patient education delivered by telephone, online, or through the mail	Promote patient adherence
	Adherence monitoring through phone or text reminders or through newer technologies, such as apps or online patient portals	Promote patient adherence
	24/7 patient support from personal case managers	Promote patient adherence; minimize costs of adverse events
	Overnight delivery and local pick-up of drugs	Increase patient convenience and reduce fulfillment time
	Refill reminders—by phone, text, or email	Optimize patient adherence
	24/7 adverse event management provided by nurse specialists	Optimize patient outcomes; reduce costs
	Waste minimizing and fill strategies	Reduce costs
Data capture and analytics	Increase client understanding of product and patients	

{ **What Are Specialty Pharmacies & What Do They Do?** }

As the number of biologic and orphan drug products expanded, the number of small, mostly regional specialty pharmacies expanded rapidly to hundreds of companies. (In 2014 the 10 largest specialty pharmacies had more than \$50 billion in drug sales.²⁾ Specialty pharmacy growth was further spurred on by the marketplace consolidation and integration the oncology community has experienced in the past decade. PBMs, health insurers, managed care organizations, GPOs, drug wholesalers, and even networks of physician practices began to buy or create their own specialty pharmacies. Consequently, coming up with an accurate definition of “specialty pharmacy” is challenging other than the broad statement that a specialty pharmacy provides specialized services for specialty drugs. To help better demonstrate what a specialty pharmacy is (and is not) Table 2, left, lists criteria for being considered a specialty drug, as well as the services that a specialty pharmacy can offer its multiple clients for managing those drugs.

A specialty pharmacy contracts with both payers and drug manufacturers—industries that have a number of common objectives for specialty drug dispensing. For example, payers and drug manufacturers both want to see optimal health outcomes for patients who take the drugs. Payers and drug manufacturers both understand that achieving these outcomes requires that patients take the drug correctly, and that education and continuing patient support are critical for ensuring adherence. Both parties also see considerable value in the information that a specialty pharmacy collects—although payers and drug manufacturers often use this data for different purposes. Drug manufacturers want to know about the effectiveness of their product, how it is being used, and obstacles to patient access; payers want to understand utilization patterns and their cost implications.

Payers and drug manufacturers also have important unshared objectives in relation to specialty pharmacy. For drug manufacturers, the high costs of bringing drugs to market drive the industry to make sure that its products reach every patient that would benefit from them. Payers, on the other hand, are concerned with the escalating costs of care. Table 2 can help you better understand how a specialty pharmacy can meet these payer and drug manufacturer goals.

{ **Physician Dispensing: The Value Proposition** }

Physician dispensing can benefit patients, oncology practices, and the healthcare community at large. The convenience of physician dispensing improves the patient experience and allows for personalized education and care from providers who patients trust and with whom they have a relationship. Physician dispensing may also help improve patient adherence. For the oncology practice, physician dispensing can bring in additional revenue and ensure that the practice is fairly compensated for the services it provides. For example, patients who receive medication from a specialty pharmacy often choose to come to their provider—and not the specialty pharmacy—for further education and to get answers to questions that may arise in the course of treatment.

In terms of the healthcare community at large, payers are clearly seeking more—not less—integrated care, and a specialty pharmacy adds yet another process (and additional cost) to the care continuum. (The profit margins realized by the specialty pharmacy industry are not readily transparent, but specialty pharmacies are for-profit companies and, as such, are not going to reduce healthcare costs.)

So how does an oncology practice compete? Although for-profit specialty pharmacies have deeper pockets and more resources than a community-based oncology practice, they also have certain marketplace limitations or vulnerabilities, including:

- Their distance from patients—both physically and in terms of relationship building with patients. As stated previously, patients have a trusted relationship with their providers that a specialty pharmacy cannot hope to duplicate.
- A number of conflicts of interest from having to serve clients with different needs and different interests, such as health insurers and drug manufacturers.
- A growing antipathy to mail order from patients, providers, and now payers. Restrictions to mail order medication are also being legislated at the state level.
- A lack of evidence that a specialty pharmacy actually improves care or the patient experience.
- A lack of transparency.

More important, oncology practices have a number of attributes that make them uniquely positioned to dispense anti-cancer drugs to patients. For example, the core activity in dispensing any medication is to get the drug into the hands of the patient, and so the most obvious advantage a dispensing oncology practice has over a specialty pharmacy is its physical proximity to patients. In addition to the comfort of knowing the prescription has been

Table 3. DATA TO MAKE THE VALUE PROPOSITION FOR PHYSICIAN DISPENSING

Manufacturer & Payer Objectives	Attribute of Physician Dispensing	Mechanism of Impact
Optimize Adherence	Proximity	Face-to-face patient education encourages greater interaction, which, in turn, improves patient comprehension, adherence, and appropriate response to AE.
	Understanding of patients	Greater ability to personalize drug education to meet the unique characteristics of patients.
		Personalization of adherence programming to meet the unique needs of patients.
		Ability to match refill reminder programs to meet patient preferences.
	Integration	Level of adherence incorporated as formal item on case review agenda (i.e., tumor board) for integrated care team. Problems identified and joint prescriber/dispenser interventions undertaken to address these concerns.

filled and received by the patient, physician dispensing removes the burden of patients having to go to another location or make another phone call to receive their medications. Further, because all providers involved in caring for the patient—physicians, pharmacists, nurses, administrators, financial navigators, social workers—are at one convenient location, oncology practices are able to deliver more integrated care to patients than what is possible through an independent specialty pharmacy.

To help communicate the value proposition of physician dispensing to payers and manufacturers, oncology practices must show how these advantages translate into benefits for these payers and drug manufacturers. Table 3 (below and continued on pages 8-9) can help oncology practices make that argument by:

- Explaining the mechanisms by which physician dispensing can advance payer and drug manufacturer goals.
- Measuring the scope or magnitude of impact that could be expected from physician dispensing.
- Identifying data that oncology practices can collect to demonstrate that they do, in fact, offer superior dispensing services in many situations.

In the end, physician dispensing can help position oncology practices to provide high-quality—and potentially lower cost—care, increasing the value proposition for both patients and payers. Further, physician dispensing can improve the patient experience by ensuring patients are not forced to use a specialty pharmacy over the convenience of their community provider. Most importantly, if payers are going to hold providers accountable for value and care quality metrics, providers must be able to fill prescriptions so that they can assume full accountability for quality and cost management.

Table 3 translates the three key advantages physician dispensing has over a large, centralized specialty pharmacy—1) proximity to the patient, 2) a thorough understanding of the patient, and 3) the ability to provide integrated care—into benefits for drug manufacturers and/or payers. The right-most column lists evidence oncology practices can use to justify these benefits. A glossary of terms used in Table 3 can be found on page 10.

Scope/Magnitude of Impact	Evidence of Impact
The impact is expected to be greatest for drugs with complex instructions.	MPR Rate of adherence-related AE.
Improvements greatest among underserved or disparate populations or patients with special needs (e.g., the elderly, non-English speakers, patients with low literacy).	MPR
Most relevant for drugs with complex dosing and/or drugs that are likely to require dose modification.	Rate of adherence-related AEs.
Most relevant for patients with unique communication profiles (e.g., no cell phones, no land lines).	Interval between predicted and actual dates for refills.
All patients with adherence issues whose cases are reviewed by integrated care team.	Number (and type) of interventions undertaken with pre-post intervention comparisons of adherence rates.

continued on pages 8-9

Table 3. DATA TO MAKE THE VALUE PROPOSITION FOR PHYSICIAN DISPENSING (continued)

Manufacturer & Payer Objectives	Attribute of Physician Dispensing	Mechanism of Impact
Cost Control	Proximity	N/A
	Understanding of patients	Better understanding of patients allows for more efficient and effective response to AE, resulting in fewer ER visits and lower rates of preventable inpatient admissions.
	Integration	Prescriber/dispenser proximity allows for more timely implementation of dosing changes, leading to lower levels of drug wastage.
Fewer AEs (or more timely management of AEs) reduces the number of unnecessary ER visits and hospital admissions.		
Provide Market & Clinical Intelligence	Proximity	N/A
	Understanding of patients	Prescriber familiarity with patients allows for more valid assessment by providers of the clinical significance of responses to therapy.
	Integration	Integration of full range of data from EHR with data on dispensing provides practices with more comprehensive set of potentially relevant variables for understanding drug-patient interaction.
Maximize Health Outcomes	Proximity	Therapy initiated sooner.
	Understanding of patients	Lower rates of AE due to more comprehensive assessment of drug-fit.
	Integration	Fewer AEs resulting from miscommunications between patient, prescriber, and dispenser.
Patient Experience	Proximity	Avoids frustrations of mail order.
		Eliminates anxiety from delays in start of therapy.
	Understanding of patients	A comprehensive understanding of patients, including their preferences, is essential to guarantee patient-centered care.
Integration	The fewer "points of contact" for the patient, the better.	
Optimize Uptake	Proximity	Minimizes time-to-therapy for initial dose of a medication.
	Understanding of patients	Greater success rate (and faster time to success) in obtaining financial assistance because of better collaboration between practice and patient.
	Integration	Proximity to physician allows for more efficient and effective response to coverage denials.

Scope/Magnitude of Impact	Evidence of Impact
N/A	N/A
Relevant for most patients being treated with relatively new drugs for which the full range of outcomes is not well defined.	Rates of visits to emergency departments and rates of hospital admissions.
Relevant for drugs with higher likelihood of need for dose-modification.	Total costs of care per patient.
Greatest impact on “complex” patients (i.e., those patients with co-morbidities or attributes likely to impact response to therapy).	Total costs of care per patient.
N/A	Utility will be judged by data and/or recipient of data, but greatest impact will be achieved when partnered with practice-generated analytics.
Greatest impact on new drugs for which evidence on “real world” effectiveness is still lacking.	
Greatest impact on new drugs for which evidence on “real world” effectiveness is still lacking.	
Relevant for relatively rare situations where 2 to 10 days difference in start date impacts course of disease.	Response rates (and associated measures of response).
Especially important for patients with co-morbidities.	Rate and severity of AE.
Greatest impact on “complex” patients (i.e., those with co-morbidities or attributes likely to impact response to therapy).	Rate and severity of AE.
Most relevant for patients whose situation makes mail delivery difficult.	Case reports/log of mail-associated problems.
Importance greatest for patients with anxiety disorders.	Patient satisfaction surveys.
Most relevant for “atypical” patients (i.e., very elderly, very young, phobic, culturally distinct) who do not fit standardized approaches.	Case reports of accommodations made and patient response.
Relevant for “misdirected” patient inquiries (e.g., calling pharmacist with question best asked of nurse).	Patient satisfaction measures, with ease of contact focus.
2 to 10 days of added use.	TTT
	MPR
Most relevant for patients with borderline/questionable eligibility for financial assistance.	Percent of lower-income patients receiving financial assistance.
	Time to resolution of applications for financial assistance.
Relevance greatest for newly-approved drugs and for drugs being used for evidence-supported off-label uses.	Time to resolution of denials.

GLOSSARY OF TERMS, TABLE 3

Adherence	The extent to which a patient's drug-taking behaviors "adhere" to labeled recommendations for use.
Adverse event (AE)	Any negative health consequence associated with taking a drug.
Costs	Measured from payer's perspective, exclusive of drug acquisition costs.
Integration	The existence of all oncology-related services (clinical, financial, administrative) within a single organization.
Market intelligence	Information about the drug-patient interaction that might inform manufacturer or payer policies or understanding.
Measures of response	Includes time-to-response, likelihood of response, and duration of effect.
Medication possession ratio (MPR)	The total number of daily doses taken by patient, divided by the total number of days patient should have been on therapy.
Outcomes	Health-related consequences of taking (or not taking) the drug.
Proximity	The physical proximity of the practice to the patient.
Patient experience	Subjective assessment by patient of all facets of care.
Time-to-therapy (TTT)	The interval from the date the prescription was written to the date the patient received the medication.
Understanding	All the interactions between the practice and the patient that extend beyond those related specifically to the drug being dispensed.
Uptake	The amount of drug dispensed.

REFERENCES

1. Suchanek D. The rise and role of specialty pharmacy. *Biotechnology Healthcare*, Oct. 2005.
2. Pembroke Consulting. The biggest in a booming pharmacy field. *N.Y. Times*. July 15, 2015. Available online at: nytimes.com/interactive/2015/07/16/business/specialty-pharmacy-top10list.html?_r=2. Last accessed Nov. 2, 2015.

WHAT CANCER PATIENTS NEED TO KNOW ABOUT ORAL MEDS

What's the difference between an infused drug and an oral drug?



Most chemotherapy drugs come as solutions that are injected or infused into patients in the doctor's office. However, some drugs are pills, tablets, or capsules that patients can take on their own. If you and your doctor decide that one of these oral drugs is the best one for you, you will be given a prescription for the drug and it will be your responsibility to get that prescription filled.

Where can I get my prescription filled?



Often you will have a choice of where you want to fill your drug prescriptions.

1. At your doctor's office (this will vary by state, and some states do not allow physicians to dispense prescriptions at all)
2. At your cancer program (an outpatient pharmacy)
3. At a retail pharmacy in your community (Walgreens, CVS, Rite Aid, etc.)
4. Through a mail order pharmacy
5. At a specialty pharmacy (for some drugs, this type of pharmacy is the only option)

With all of these choices, how do I make the decision that is best for me?



The following table shows how the dispenser (the place where your prescription is filled or the person who fills your prescription) can help you with your oral drug. It lists:

1. The dispenser's responsibilities
2. Reasons why those responsibilities are important
3. The different ways in which dispensers fulfill each responsibility
4. What you—as the patient—can do to help

Deciding which dispenser is best for you depends on many different factors, including your insurance, the specific drug you are prescribed, whether your doctor's office dispenses that drug, and most important, your personal preferences. You and your doctor can use this information to decide the best way for you to get your prescription filled.

HOW PRESCRIPTION DRUG DISPENSERS & PATIENTS CAN COLLABORATE ON QUALITY CARE

Dispenser's Responsibility	Why This Is Important	How Dispensers Do It	Your Role
Make sure it is safe for you to take the drug.	Some cancer drugs can be unsafe (or less effective) if they interact with drugs you are already taking. Your doctor will check for possible interactions (or allergies to the drug) when prescribing, but having the dispenser run another check is a good idea.	The dispenser enters the name of the prescribed drug into a reference database and sees whether it interacts with any drug, vitamin, or supplements that you are taking.	Both your doctor and the dispenser depend on you to give them the complete list of all the drugs, vitamins, and supplements you are taking. You also need to alert both the dispenser and your doctor if that list changes.
Check that your health insurance will pay for the drug.	Most insurance companies require the dispenser to get approval before they give you the oral cancer drug or else the insurance company will not pay for it.	The dispenser submits a request to the insurance company for authorization to give you the drug. If the insurance company denies the request, the dispenser can appeal or ask your doctor to appeal that decision.	Make sure your insurance information is up to date and correct. The dispenser may ask you to contact your insurance company if there is a problem.
Get the drug to you.	This will allow you to follow the treatment regimen your doctor has prescribed to treat your cancer.	Some dispensers mail the drug to you, some require you to pick it up, and some will give you a choice of which method you prefer.	If both options are available, tell the dispenser which you prefer. If the drug is sent by mail, let the dispenser know of any special arrangements you might need. For example, whether you need confidential packaging, live in a building with restricted access, or need someone else to sign for the drug.
Explain to you the correct way to take the drug.	Cancer drugs often have a long list of "do's" and "don'ts," for example whether the drug must be taken with or without food, what to do if you miss a dose, and when it might be necessary to reduce the dose. Following instructions is important if the drug is to be safe and effective.	If you pick up the drug, the dispenser will meet with you and go through the instructions. If you get the drug in the mail, the dispenser will usually call and explain how to take the drug. Some dispensers use video chats to go over these instructions. Most will give (or send) you written material with instructions.	Make sure you understand the instructions. It often helps to read the instructions aloud to the dispenser.

Dispenser's Responsibility

Why This Is Important

How Dispensers Do It

Your Role

Help you take the drug correctly.

It can take days or weeks until taking the drug becomes part of your routine. Even then, things can come up (travel, minor illness) that might throw you off your routine.

There are many different types of dispensing programs. Some wait for you to contact them if you need help. Others will contact you just to check on things. Some contact you every few weeks. Others get in touch every day. Some will have a person call, while others use automated calls or texts as reminders.

Ask the dispenser for the contact options and tell the dispenser which option you prefer. If you are finding it difficult to stay on track, contact the dispensing program immediately.

Explain what you should expect when you take the drug.

Cancer drugs can have both expected and unexpected effects. Some effects can be ignored and some need your immediate attention.

The dispenser does this at the same time that he or she explains how to take the drug correctly. That means some will do it in person, others by phone, and some by video chat.

Make sure the dispenser has answered all your questions, including when you need to contact someone and who that person should be (your doctor, the dispenser).

Answer any questions that you might have about the drug once you start taking it.

Even with the best preparation, questions may come up while you are taking the drug. For example, "Is it a problem if the pills sat in the sun for an hour?"

All dispensers will have phone numbers for you to call. Some also respond to e-mail and to text or e-chat messages.

Be clear on who to contact for different types of questions, the best times to get in touch, and who to call if questions come up at night or on weekends.

Manage prescription refills.

It may be unsafe to suddenly stop taking a drug. Also, many drugs are less effective if they are not taken every day. The dispenser needs to make sure the drug is available when you need it and that you know to get the drug on time.

Dispensers can use phone, e-mail, and text to remind you that it is almost time for a refill.

Let the dispenser know how you would like to be contacted and the best time (the day before, a few days before, time of day).

Help patients who need financial assistance.

The patient "co-pay" for cancer drugs (the amount you are responsible for) usually runs about one-quarter to one-third of the full cost. This can be hundreds (or even thousands) of dollars every month. Fortunately there are programs that can help patients who cannot afford to pay for their drugs.

Many (but not all) dispensers can help you find financial support, if you need it. Many dispensers know the programs that provide financial assistance for your specific drug. They can fill out the application or help you fill out the application. They can also help you with an appeal if necessary.

All patient assistance programs ask for proof of income level—usually recent tax returns—which you will need to have ready. Some require you (not the dispenser or your doctor) to submit the application for aid.



Association of Community Cancer Centers
This publication is a benefit of membership.

11600 Nebel Street, Suite 201
Rockville, MD 20852
301.984.9496 | acc-cancer.org



Funding and support provided by Janssen Biotech, Inc