INNOVATIVE STRATEGIES TO MANAGE ORAL ONCOLYTICS AND INFUSION THERAPY
CBI SPECIALTY THERAPIES FORUM
LAS VEGAS, NV

Debbie Stern, RPh
SVP, Business Development and Strategy
AGENDA

- State of Cancer Care
- Challenges with Oncology Management
- Payer Management Strategies: Current and Future
- Improve Clinical Support and Patient Care
AGENDA

State of Cancer Care
## CANCER FACTS

<table>
<thead>
<tr>
<th>1.7 Million</th>
<th>• Number of new cancer cases expected to be diagnosed in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,620</td>
<td>• Number of Americans expected to die of cancer per day</td>
</tr>
<tr>
<td>#2</td>
<td>• Rank of causes of cancer deaths is in US (CV is #1)</td>
</tr>
<tr>
<td>78%</td>
<td>• % of all cancer diagnoses in people 55 years of age or older</td>
</tr>
<tr>
<td>32%</td>
<td>• Expected cancer prevalence rate increase from 2010 to 2020</td>
</tr>
<tr>
<td>39%</td>
<td>• Increase in 5-year survival rates across all cancer types since 1975</td>
</tr>
</tbody>
</table>

National Cancer Institute, PHRMA Medicines in Development, Cancer 2014
### LEADING SITES OF NEW CANCER CASES AND DEATHS (2015 ESTIMATE)

#### Estimated New Cases*

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th></th>
<th>Female</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prostate</strong></td>
<td>220,800 (26%)</td>
<td>Breast</td>
<td>231,840 (29%)</td>
<td></td>
</tr>
<tr>
<td><strong>Lung &amp; bronchus</strong></td>
<td>115,610 (14%)</td>
<td>Lung &amp; bronchus</td>
<td>105,590 (13%)</td>
<td></td>
</tr>
<tr>
<td>Colon &amp; rectum</td>
<td>69,090 (8%)</td>
<td>Colon &amp; rectum</td>
<td>63,610 (8%)</td>
<td></td>
</tr>
<tr>
<td>Urinary bladder</td>
<td>56,320 (7%)</td>
<td>Uterine corpus</td>
<td>54,870 (7%)</td>
<td></td>
</tr>
<tr>
<td>Melanoma of the skin</td>
<td>42,670 (5%)</td>
<td>Thyroid</td>
<td>47,230 (6%)</td>
<td></td>
</tr>
<tr>
<td>Non-Hodgkin lymphoma</td>
<td>39,850 (5%)</td>
<td>Non-Hodgkin lymphoma</td>
<td>32,000 (4%)</td>
<td></td>
</tr>
<tr>
<td>Kidney &amp; renal pelvis</td>
<td>38,270 (5%)</td>
<td>Melanoma of the skin</td>
<td>31,200 (4%)</td>
<td></td>
</tr>
<tr>
<td>Oral cavity &amp; pharynx</td>
<td>32,670 (4%)</td>
<td>Pancreas</td>
<td>24,120 (3%)</td>
<td></td>
</tr>
<tr>
<td>Leukemia</td>
<td>30,900 (4%)</td>
<td>Leukemia</td>
<td>23,370 (3%)</td>
<td></td>
</tr>
<tr>
<td>Liver &amp; intrahepatic bile duct</td>
<td>25,510 (3%)</td>
<td>Kidney &amp; renal pelvis</td>
<td>23,290 (3%)</td>
<td></td>
</tr>
<tr>
<td>All sites</td>
<td>848,200 (100%)</td>
<td>All sites</td>
<td>810,170 (100%)</td>
<td></td>
</tr>
</tbody>
</table>

#### Estimated Deaths

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th></th>
<th>Female</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung &amp; bronchus</td>
<td>86,380 (28%)</td>
<td>Lung &amp; bronchus</td>
<td>71,660 (26%)</td>
<td></td>
</tr>
<tr>
<td>Prostate</td>
<td>27,540 (9%)</td>
<td>Prostate</td>
<td>40,290 (15%)</td>
<td></td>
</tr>
<tr>
<td>Colon &amp; rectum</td>
<td>26,100 (8%)</td>
<td>Colon &amp; rectum</td>
<td>23,600 (9%)</td>
<td></td>
</tr>
<tr>
<td>Pancreas</td>
<td>20,710 (7%)</td>
<td>Pancreas</td>
<td>19,850 (7%)</td>
<td></td>
</tr>
<tr>
<td>Liver &amp; intrahepatic bile duct</td>
<td>17,030 (5%)</td>
<td>Liver &amp; intrahepatic bile duct</td>
<td>7,520 (3%)</td>
<td></td>
</tr>
<tr>
<td>Esophagus</td>
<td>12,600 (4%)</td>
<td>Liver &amp; intrahepatic bile duct</td>
<td>7,520 (3%)</td>
<td></td>
</tr>
<tr>
<td>Urinary bladder</td>
<td>11,510 (4%)</td>
<td>Liver &amp; intrahepatic bile duct</td>
<td>7,520 (3%)</td>
<td></td>
</tr>
<tr>
<td>Leukemia</td>
<td>10,240 (4%)</td>
<td>Leukemia</td>
<td>10,240 (4%)</td>
<td></td>
</tr>
<tr>
<td>Uterine corpus</td>
<td>10,170 (4%)</td>
<td>Uterine corpus</td>
<td>10,170 (4%)</td>
<td></td>
</tr>
<tr>
<td>Non-Hodgkin lymphoma</td>
<td>8,310 (3%)</td>
<td>Non-Hodgkin lymphoma</td>
<td>8,310 (3%)</td>
<td></td>
</tr>
<tr>
<td>Brain &amp; other nervous system</td>
<td>6,380 (2%)</td>
<td>All sites</td>
<td>277,280 (100%)</td>
<td></td>
</tr>
</tbody>
</table>

*Excludes basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder.

American Cancer Society Facts and Figures 2015
ASCVO Value in Cancer Care Task Force
Define challenges related to the cost of cancer care and develop strategies to address these challenges
- Increase MD education and guidance about cost
- Increase patient education and assistance regarding cost
- Promote high value medical decision making
- Assure value care

Value Framework
Assess relative value of cancer care options related to:
- Clinical benefit (OS, Palliation, QOL)
- Toxicity
- Cost
THE CANCER CARE DELIVERY SYSTEM IS IN CRISIS

Cancer Care is OFTEN NOT:
- Patient Centered…
- Evidence Based…
- Coordinated

The Goal of Cancer Care Delivery

Institute of Medicine 2013
AGENDA

Challenges with Oncology Management
ASCO Choosing Wisely
Opportunities to Improve Quality and Value in Cancer Care

• Appropriate anti-emetic use
• Appropriate use of colony stimulating factors (CSFs)
• Limit combination therapy for metastatic breast cancer
• Use targeted therapy only when biomarker is present
• Focus on palliative care vs. chemotherapy for patients with advanced solid tumor cancers
• Manage use of PET or PET-CT and radionuclide bone scans
• Appropriate use of PSA screening for prostate cancer

Adapted from ASCO Choosing Wisely 2012, 2013
## A CASE OF OVERUSE AND UNDERUSE

<table>
<thead>
<tr>
<th>Study Title</th>
<th>Use of CSF with Chemotherapy: Opportunities for Cost Savings and Improved Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study Goal</td>
<td>Identify appropriate use of CSFs in a multiregional population-based cohort of lung and colorectal cancer patients (N = 1849)</td>
</tr>
<tr>
<td>Findings</td>
<td>Only 17% of patients treated with high-risk chemotherapy regimens received CSFs</td>
</tr>
<tr>
<td></td>
<td>Overall, 96% of CSFs were administered in scenarios where CSF therapy is not recommended by evidence-based guidelines</td>
</tr>
<tr>
<td>Conclusions</td>
<td>The authors suggest that policies to decrease CSF use in patients at lower or intermediate risk of FN may yield substantial cost savings without compromising quality of care.</td>
</tr>
</tbody>
</table>

FRAGMENTED CANCER MANAGEMENT

Diagnostic
- Advanced Imaging
- Lab/Genetic Testing
- Pathology
- Histology

Treatment
- Surgery
- Radiation Therapy
- Drug Therapy (RX and Medical Benefit)
- Personalized Medicine

Care Management
- Case Management
- Palliative Care
- Hospice
- Nutrition
- Comorbidities
ONCOLOGY DRUG FACTS

- Oncologics rank 1st in spend by therapeutic class\(^1\)
- Oncologics represent >$23B spend\(^1\)
- Drugs represent about ¼ of total cancer treatment costs\(^2\)
- >50% of specialty drugs under development are targeted toward cancer (~300 Phase II & III)\(^3\)
- High trend rate due to\(^1\):
  - Increased incidence of cancer
  - Robust pipeline with virtual guaranteed covered by insurers
  - Insurance reimbursement policies that encourage use of brands (ASP +)
  - Post-launch price increases

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\(^2\) Newcomer, L. Myths and Realities in Cancer Care: Another Point of View. *Health Affairs*, 33(10): 1805-1807.

BENEFIT COVERAGE OF SPECIALTY DRUGS (COMMERCIAL)

Oncology drug spend
- >70% covered under medical benefit
- Spend on orals increased 37% from 2007-2011

1Specialty Drugs

<table>
<thead>
<tr>
<th></th>
<th>RX Benefit</th>
<th>Medical Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncology</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td>Non-oncology</td>
<td>40%</td>
<td>60%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Orals Supportive Care</th>
<th>Infused Supportive Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncology</td>
<td>$2.43 PMPM</td>
<td>$5.67 PMPM</td>
</tr>
<tr>
<td>Non-oncology</td>
<td>$8.10 PMPM</td>
<td>$27 PMPM</td>
</tr>
</tbody>
</table>

1Prime Therapeutics Specialty Drug Trend Report 2014
ORAL DRUGS

- Increase in development and availability of orals
  - Coverage under Med Part D
  - Targeted therapies = used for chronic therapy
- Typically more convenient for patients
- Mandatory coverage in Part D (1 of 6 protected classes)
- Adherence to oral agents is highly variable, ranging from 16% - 100% depending on study
  - Several studies identify higher medical costs and poorer outcomes associated with low adherence
- 26 states have passed cost share parity laws
- Manufacturer price increases impact affordability
PRICE INCREASES IN ORAL DRUGS

Change in AWP Unit Cost, 2007-2014

- Tarceva 100mg: $118.78 to $306.43 (158%)
- Sprycel 50mg: $115.13 to $219.69 (91%)
- Gleevec 400mg: $87.60 to $203.86 (133%)
- Xeloda 500mg: $19.29 to $43.47 (125%)

CANCER DRUG PIPELINE

- Nearly 800 medicines and vaccines in clinical testing for cancer (all phases)
- New designation of breakthrough therapies (expedited development and review):
  - 7 of 17 original and supplemental breakthrough approvals are for cancer

Focus of Cancer Pipeline

**Personalized Medicines**
- Therapeutics tailored to individual genetic makeup

**Targeted Therapies**
- Designed to interfere with specific molecular targets involved in cancer cell growth or progression
- Significant growth: 11% - 46% (2003-13)

**Therapeutic Cancer Vaccines**
- Harness the power of the immune system to fight cancer rather than to prevent it

**Preventive Vaccines**
- Target viruses that can cause or contribute to the development of cancer

AGENDA

Payer Management Strategies: Current and Future
PAYER STRATEGIES TO MANAGE SPEND AND TREND

- Post Service Claims
- Clinical and Utilization Management
- Drug Cost
MEDICAL BENEFIT SPECIALTY DRUG CHALLENGES:

DRUG COST

- Reimbursement varies by site of service and individual provider
  - AWP, ASP or % of billed charges
- Administration shifting to more expensive site of service (hospital out-patient)
- Difficult for payers to manage site of service
- ASP + and AWP – reimbursement rates incent use of higher cost drugs
- Minimally effective at promoting lower cost treatment regimens
MECHANISMS TO MANAGE DRUG COST

• Modify Provider Reimbursement
  • Fair market value reimbursement
  • Bundled payments, episode of care payment

• Equalize Reimbursement across Sites of Service
  • Outpatient, home infusion, ambulatory infusion, MD office

• Site of Service Redirection
  • Direct patients to lowest cost/most convenient site of service

• Partial Fill
  • Where applicable, implement partial fill strategies to lower amount of drug dispensed

• Rebates and Total Cost of Care Management
  • Rebate opportunities to identify preferred products or formulary inclusion
  • Promote use of equally efficacious treatment regimens with lowest cost
Drug costs can be DOUBLE the cost of MD office, home infusion or other infusion sites
Q. Has your organization implemented a partial/split fill prescription program? If so, which therapy categories are included in your program?

Others include: HCV (SC), MS (SC, IM) CF, LS Diseases, RA/CD/FS (SC, IM), hemophilia

Adapted from EMD Serono Specialty Digest, 10th edition
### TREATMENT COST VARIABILITY:
1\textsuperscript{st} LINE COMBINATION REGIMENS IN THE NCCN GUIDELINES FOR METASTATIC COLORECTAL CANCER

Treatment costs range from $2,200 - $10,000 per cycle

<table>
<thead>
<tr>
<th>Initial Regimen</th>
<th>Median OS</th>
<th>1 Cycle</th>
<th>6 mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>CapeOx + bevacizumab</td>
<td>21.3 mo</td>
<td>$10,077</td>
<td>$80,617</td>
</tr>
<tr>
<td>mFOLFOX6 + panitumumab</td>
<td>23.9 mo</td>
<td>$6,535</td>
<td>$78,420</td>
</tr>
<tr>
<td>mFOLFOX6 + bevacizumab</td>
<td>21.3 mo</td>
<td>$5,005</td>
<td>$60,065</td>
</tr>
<tr>
<td>FOLFIRI + cetuximab</td>
<td>23.5 mo</td>
<td>$4,400</td>
<td>$52,795</td>
</tr>
<tr>
<td>FOLFIRI + panitumumab</td>
<td>NA</td>
<td>$3,777</td>
<td>$45,325</td>
</tr>
<tr>
<td>FOLFOXIRI</td>
<td>22.6 mo</td>
<td>$2,911</td>
<td>$34,929</td>
</tr>
<tr>
<td>FOLFIRI + bevacizumab</td>
<td>28.0 mo</td>
<td>$2,248</td>
<td>$26,971</td>
</tr>
</tbody>
</table>

Treatment costs range from $2,200 - $10,000 per cycle.

Ramsey, S, Shankaran, V. Managing the Financial Impact of Cancer Treatment: The Role of Clinical Practice Guidelines. JNCCN 2012; 10(8)
**TREATMENT COST VARIABILITY: TRIPLE DRUG FIRST LINE SYSTEMIC CHEMOTHERAPY OPTIONS FOR METASTATIC GASTRIC CANCER IN THE NCCN GUIDELINES**

Treatment costs range from $100 - $7,000 per cycle

<table>
<thead>
<tr>
<th>Initial Regimen</th>
<th>Median OS</th>
<th>1 Cycle</th>
<th>6 mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECF</td>
<td>9.9 mo</td>
<td>$105</td>
<td>$839</td>
</tr>
<tr>
<td>DCF</td>
<td>9.2 mo</td>
<td>$1,534</td>
<td>$9,207</td>
</tr>
<tr>
<td>ECX</td>
<td>9.9 mo</td>
<td>$2,269</td>
<td>$18,153</td>
</tr>
<tr>
<td>EOF</td>
<td>9.3 mo</td>
<td>$4,421</td>
<td>$35,365</td>
</tr>
<tr>
<td>EOX</td>
<td>11.2 mo</td>
<td>$7,185</td>
<td>$57,478</td>
</tr>
</tbody>
</table>
Clinical and Utilization Management
1 in 3 patients treated with chemo do not receive a treatment plan consistent with current medical evidence¹

- Complex authorization criteria
- Multiple therapy options with variability in efficacy, toxicity and cost
- PA criteria difficult to enforce under medical benefit and across sites of service
- Difficult to determine value of complex lab/molecular diagnostic testing

¹Hall, D. Plans Tackle Cancer Care. Managed Healthcare Executive, Sept 2014
MECHANISMS TO MANAGE UM AND CM

- **Prior Authorization**
  - Traditional PA with single drug authorization

- **Clinical Pathways**
  - Disease based treatment pathway resulting in recommended therapy regimen (single or multi-drug)

- **Genetic Testing Requirements for RX**
  - Ensure drug is appropriate for the patient based on genetic makeup

- **Case/Disease Management**
  - Managing the patient’s total care

- **Adherence Programs**
  - Identifying and managing factors impacting adherence to therapy
**Prior Authorization is Not Uniformly Applied Across Medical Benefit Specialty Drugs**

Q. Indicate which of the following provider-administered drug categories require PA.

<table>
<thead>
<tr>
<th>Provider-administered Drugs That Require PA</th>
<th>% of Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botulinum Toxins</td>
<td>88%</td>
</tr>
<tr>
<td>RA/CD/PS (IV)</td>
<td>85%</td>
</tr>
<tr>
<td>ITP</td>
<td>85%</td>
</tr>
<tr>
<td>MS (IV)</td>
<td>78%</td>
</tr>
<tr>
<td>RSV</td>
<td>75%</td>
</tr>
<tr>
<td>HFH</td>
<td>70%</td>
</tr>
<tr>
<td>PAH (Inj)</td>
<td>67%</td>
</tr>
<tr>
<td>HAE</td>
<td>67%</td>
</tr>
</tbody>
</table>

PA <65%

<table>
<thead>
<tr>
<th>Therapy Category</th>
<th>% PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1AD</td>
<td>64%</td>
</tr>
<tr>
<td>CF</td>
<td>64%</td>
</tr>
<tr>
<td>LSD Therapies (IV)</td>
<td>62%</td>
</tr>
<tr>
<td>Oncology (IV)</td>
<td>60%</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>58%</td>
</tr>
<tr>
<td>HA Derivatives</td>
<td>56%</td>
</tr>
<tr>
<td>Immune Globulins</td>
<td>56%</td>
</tr>
<tr>
<td>Lupus</td>
<td>56%</td>
</tr>
</tbody>
</table>

Adapted from EMD Serono Specialty Digest, 10th edition
MECHANISMS FOR TREATMENT AUTHORIZATION

- MD fax or phone for authorization (individual drugs)
- Individual drug e-PA via web portal
- Treatment regimen e-PA via web portal
- Integrated into electronic health record (EHR)
MANAGING DRUGS ALSO requires managing LAB/GENETIC TESTING

Genetic lab challenges facing payers trending 20%, representing >$3PMPM\(^1\)

- **Increasing Number of Drug Approvals with Companion Diagnostics**
  - More than two new genetic tests launched each week

- **Knowledge Gap in Genetic Testing**
  - Genetic labs and test manufacturers influence physicians and patients

- **Genetic Lab Test Overpayment**
  - Coding complexity results in overpayment

\(^1\)Data on File. CareCore National/MedSolutions
Complicated treatment regimens taking into consideration:
• Diagnosis at onset
• Stage of disease
• Clinical presentation
• Histology
• Pathology
• Comorbidities
• Patient risk factors
• ECOG status
• Genetic alterations
• Other factors depending upon cancer type

Adapted from NCCN by CareCore National|MedSolutions
PATHWAY PROGRAMS

- Variety of vendors
- Pathway program differentiators:
  - Clinical source for pathways
  - Ease of use/MD acceptance
  - Authorization capabilities
  - Ownership/potential conflicts of interest
  - Inclusion of multiple treatment modalities
    - Lab/Genetic Testing
    - Radiation Therapy
    - Advanced Imaging
    - End-of-life Care
DRUG TREATMENT IS NOT ALWAYS THE BEST CHOICE

**Patient Case Study #1**
- Breast cancer with disease progression
- HER2-, ER-, PR-
- ECOG status poor (>2)
- MD requested doxorubicin
- NCCN guideline recommendation to transition to palliative symptom management

**Patient Case Study #2**
- Asymptomatic unresectable metastatic, inoperable rectal cancer
- Disease progression after 4th line of therapy
- MD requested 5-FU, oxaliplatin, leucovorin
- NCCN guideline recommendation for clinical trial or supportive care

1Data on File. CareCore National|MedSolutions
PAYER STRATEGIES TO MANAGE SPEND AND TREND

Claims
MEDICAL BENEFIT SPECIALTY DRUG: CLAIMS

- Claim payment coding varies by site of service
  - NDC for SP and home infusion, J-code or REV code for MD and OP facility, bundled claims, encounter data
  - J-code billing units complicated and confusing
  - Difficult to identify actual drug on NOC codes
  - Payer medical claims payment systems not equipped to adjudicate drug claims by NDC and to apply claim edits
MECHANISMS TO MANAGE CLAIMS

- **Rely on internal medical claims system edits**
  - Minimal edits available
- **Outsource to vendor**
  - Post service pre-payment edits
  - Post service post-payment audit
CLAIMS EDITING OPPORTUNITIES

ICD-9 match -> HCPCS code -> Quantity

PA match -> Pricing -> Duplicate claims

NDC for NOC -> SAVINGS
OPPORTUNITY TO MANAGE UNITS AND REIMBURSEMENT

- Dosage >2 times over average recommended dose
- Up to 10X difference in amount paid depending on site of service
**COMPLEXITY OF HCPCS CODING**

Need accurate billing unit and quantity, taking into consideration multi-dose vs single dose vial

<table>
<thead>
<tr>
<th>J2505 Pegfilgrastim (Neulasta)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indication</strong></td>
</tr>
<tr>
<td><strong>Dose:</strong></td>
</tr>
<tr>
<td><strong>Packaging:</strong></td>
</tr>
<tr>
<td><strong>HCPCS Quantity</strong></td>
</tr>
<tr>
<td><strong>HCPCS Billing unit</strong></td>
</tr>
<tr>
<td><strong>2014 ASP cost/billing Unit</strong></td>
</tr>
</tbody>
</table>

*Neulasta PI, CMS.gov*
AGENDA

Improve Clinical Support and Patient Care
Standard oncology care vs. standard care + palliative care consultation improved QOL, OS, used less chemo and had less aggressive end of life care.  

Nationwide, the average number of hospice days per patient in the last six months of life increased substantially, from 12.4 days to 18.3 days (2003-2007)

99% of terminally ill patients with cancer cite their home as their preferred site of care, yet only 33% die there

Payers looking at partnering with MD and patient to make end-of life decisions to improve patient quality of life, reduce hospitalizations and ED visits

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1 Newcomer, L. Myths and Realities in Cancer Care: Another Point of View. *Health Affairs*, 33(10): 1805-1807.
2 Trends and Variation in End-of-Life Care for Medicare Beneficiaries with Severe Chronic Illness, Dartmouth Atlas 2011.
ACHIEVING THE GOAL OF ACCESSIBLE, AFFORDABLE HIGH QUALITY CARE

Future cancer care management:
- Integrated care management
- Improved provider and patient communication
- Proactive treatment planning
- Clinical and utilization management decisions based on clinical and cost effectiveness

Adapted from Institute of Medicine 2013
Appendix
ASCO Choosing Wisely
Opportunities to Improve Quality and Value in Cancer Care

2013 Top 5 List

1. Don’t use antiemetics indicated for HET for patients on LET or MET.

2. Don’t use combination chemotherapy (multiple drugs) for metastatic breast cancer unless the patient needs a rapid response to relieve tumor-related symptoms.

3. Avoid using PET or PET-CT scanning as part of routine follow-up care unless there is high-level evidence that such imaging will change the outcome.

4. Don’t perform PSA testing for prostate cancer screening in men with no symptoms of the disease when they are expected to live less than 10 years.

5. Don’t use a targeted therapy intended for use against a specific genetic aberration if the biomarker is not present.

2012 Top 5 List

1. Focus on symptom relief and palliative care for patients with advanced solid-tumor cancers rather than chemotherapy.

2. Do not use PET, CT and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.

3. Do not use PET, CT and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.

4. Do not use routine blood tests for biomarkers and advanced imaging tests to screen for recurrence for individuals who have completed curative breast cancer treatment and have no physical symptoms of recurrence.

5. Avoid administering colony stimulating factors (CSFs) to patients undergoing chemotherapy who have < 20% percent risk for febrile neutropenia.