PQI IN ACTION

Positive Quality Intervention

NCODA

Pacritinib (VONJO®) In Cytopenic Myelofibrosis

INTRODUCTION

NCODA created the Positive Quality Intervention (PQI), a peer-reviewed clinical guide for healthcare professionals, to highlight opinions and experiences from oncology experts within medically integrated teams at leading cancer centers. Each PQI outlines standards and effective practices around a specific aspect of cancer care, equipping multidisciplinary care teams with a resource for managing patients receiving oral or IV oncolytics to achieve the best outcomes.

This article explores how the care teams at Florida Cancer Specialists & Research Institute, Texas Oncology, and Emory Healthcare|Winship Cancer Institute incorporate PQIs as part of their daily workflow and how the Pacritinib (VONJO®) in Cytopenic Myelofibrosis PQI in Action elevates patient care. The guide includes Pearls, The PQI Process, Background, Indications/Mechanism of Action/Clinical Research, Adverse Effect Management and Patient-Centered Activities.

PEARLS: A Prelude to This PQI in Action AND PACRITINIB (VONJO®)

THE MEDICALLY INTEGRATED PHARMACY (MIP):

a hallmark of excellent cancer centers. An on-site pharmacy optimizes the process of filling specialty prescriptions and promotes a patient-centered, multidisciplinary team approach. Results include enhanced patient outcomes, adherence, cost effectiveness and heightened communications.

THE PACRITINIB (VONJO®) IN CYTOPENIC MYELOFIBROSIS PQI:

a guide to clinical considerations and adverse effect management for the use of pacritinib in cytopenic myelofibrosis (CMF) in patients ineligible for transplant.

MYELOFIBROSIS (MF):

a rare, chronic blood cancer that manifests in the bone marrow. The scarred marrow disrupts normal blood cell production. The disease may develop into the rarer, harder-to-treat CMF.[1-3]

CYTOPENIC MYELOFIBROSIS:

a myelodepletive phenotype of primary MF, where bone marrow mutations evolve into anemia (deficiency of red blood cells that carry oxygen and iron) and thrombocytopenia (deficiency of blood-clotting platelets). CMF mimics bone marrow failure, and the presence of high-risk mutations indicates worse outcomes.[1-3]

PACRITINIB (VONJO®):

the first approved therapy that specifically addressed the needs of patients with CMF.[1] The U.S. Food and Drug Administration (FDA) granted accelerated approval for pacritinib in 2022 for the treatment of adults with intermediate or high-risk primary or secondary MF (with post-polycythemia vera or post-essential thrombocythemia) and a platelet count below 50 × 10^9/L.[1]

A pooled analysis of clinical trials showed clinically significant benefits, including reduced spleen size and improved symptoms for patient quality of life in patients with severe thrombocytopenia.[2]

This PQI incorporates the latest National Comprehensive Cancer Guidelines, which recommend pacritinib for higher-risk MF patients — who are not transplant eligible — as first- or second-line treatment regardless of platelet count.[4]

The NCCN also recommends pacritinib in the management of MF-associated anemia in patients with or without splenomegaly and/or constitutional symptoms.[4] Sobi Inc. produces the oral inhibitor, taken in capsule form at home.

THE PARTICIPANTS

FLORIDA CANCER SPECIALISTS & RESEARCH INSTITUTE (FLORIDA CANCER SPECIALISTS)/RX TO GO

Fort Myers, Florida

Florida Cancer Specialists & Research Institute, now in its 40th year, is committed to world-class cancer care in the Sunshine State. More than 250 physicians and 280 nurse practitioners and physician assistants staff nearly 100 sites. Focuses include early and advanced cancers, blood disorders, leukemias, lymphomas and gynecologic oncology. Florida Cancer Specialists experts blend compassionate care with leading-edge technologies including genomic DNA-based treatments and immunotherapy. The Rx To Go pharmacy, directly integrated with Florida Cancer Specialists, coordinates the 24/7 pharmacy and delivery of specialty drugs to patients statewide.

Mahdi Taha, DO, FACOI, FACP
Hematologist-Medical Oncologist
Medical Oncology Director at Delray Medical Center
Associate Clinical Professor
Florida Atlantic University – Charles E. Schmidt College of Medicine

Taelor Kestner PharmD, CSP
Associate Director of Clinical Specialty Pharmacy Operations

Erin Sypolt, RPh, PharmD, BCOP
Clinical Pharmacist Supervisor

Nina DiPierro, PharmD, BCOP
Clinical Oncology Pharmacist

Nicole Bentivegna, PharmD, BCOP
Clinical Pharmacy Services Manager

TEXAS ONCOLOGY

San Antonio, Texas

Texas Oncology, founded to deliver community cancer care in 1986, has more than 280 cancer treatment centers in the Lone Star State and Oklahoma. The independent, physician-led organization of 500 doctors is known for high-quality, evidence-based care and clinical trials. Texas Oncology-San Antonio Medical Center, with nearly 50 infusion chairs, is the largest of the 45 sites with integrated pharmacies (the Baylor Charles A. Sammons Cancer Center in Dallas provides mail-order services to others). Pharmacists fill over 220,000 prescriptions for 66,000 Texas Oncology patients yearly.

Melissa Crawley, MD
Medical Oncologist/Hematologist

Julio Quintanilla, PharmD
Pharmacist Manager

Vonda McClendon, CPhT
Pharmacy Technician

EMORY HEALTHCARE | WINSHIP CANCER INSTITUTE

Atlanta, Georgia

Winship Cancer Institute at Emory University Hospital is a research-treatment center and the only National Cancer Institute-designated Comprehensive Cancer Center in Georgia. The oncology program, ranked by U.S. News & World Report as one of the best in the nation, sees 17,000 new patients annually. A new addition: Winship Cancer Institute at Emory Midtown, a full-service, 17-story oncology center housing multidisciplinary care "communities" for inpatients, outpatients and clinical trials. Both Emory University Hospital and the Midtown facility have on-site pharmacies.

Anthony M. Hunter, MD
Assistant Professor, Department of Hematology and Medical Oncology at the University of Emory School of Medicine
Medical Director, Rollins Intermediate Cancer Center at Winship Care Institute of Emory University, Leukemia Group

Belinda Li, PharmD, BCOP
Hematology/Oncology Clinical Pharmacy Specialist/Leukemia

Caroline Prentice, CPhT
Pharmacy Technician

The Medically Integrated Pharmacy and the PQI Process:

RESOURCES FOR BUSY CLINICIANS

THE PQI outlines the intervention step by step, with clinician-directed guidance and criteria that can benefit the whole team. Key segments illustrate how integrated pharmacies support physicians and clinical staff by lending their medical and administrative expertise.

The guide “really improves the overall outcome of the patient,” said pharmacy technician Vonda McClendon, CPhT, of Texas Oncology.

“It’s invaluable, as far as ensuring that the nurse and the doctor and even the lab team are all included. Everybody has the same information in one centralized setting.”

All parties share updates with the healthcare team via the patient's Electronic Health Record (EHR), documenting real-time clinician- and patient-related changes. Ongoing communications track the care continuum.

For Mahdi Taha, DO, FACOI, FACP, a PQI-powered, medically integrated pharmacy is a highly valued resource for busy physicians.

The oncologist-hematologist has more time for office visits while the Rx To Go team shepherds specialty prescriptions, oversees prior authorizations and financial assistance, and offers side effect management to patients.

At a previous post, “I was signing all these documents, all these forms, and they (pharmacists) have just taken that out of my hands and made it so much better for myself,” Dr. Taha said. "They've made it so much better for the patient, too. They're able to spend time with the patient, talk to them about medication side effects."

The PQIs not only keep multidisciplinary teams on the same page, they showcase new protocols, processes and best care practices. PQIs "have always been helpful to me," said colleague Nicole Bentivegna, PharmD, BCOP, Clinical Pharmacy Services Manager of Rx To Go.

"If I read through one and see something that someone else is doing, I'm always, like, 'Oh, we should take that back to our practice.' It's gaining ideas, things that other people are doing, and incorporating them into your practice, too."

The PQI is a time-saver, agreed oncologist Anthony Hunter, MD, who has to make every minute count. A clinical investigator, he doubles as Medical Director of the Rollins Immediate Care Center at the Winship Cancer Institute of Emory University.

He also serves as an Assistant Professor in the Department of Hematology and Medical Oncology at Emory’s medical school.

At the clinic, MF/CMF patients make up about 75% of his caseload. PQIs keep the multidisciplinary team — including the specialty oncology team and staff at two integrated pharmacies — aligned with patients and protocols. On staff: nine specialty pharmacists, six specialty technicians, four medication assistance coordinators, three medication access specialists, and pharmacy interns. Pharmacy hours are 8 a.m. to 5 p.m. weekdays, and a pharmacist is available by phone after-hours for emergency pharmacy needs.

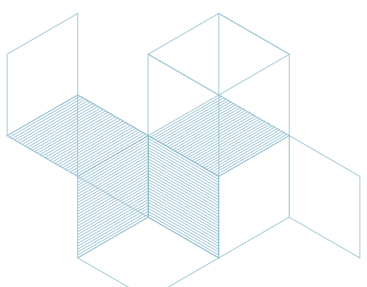
“As a physician, it (the team) saves me a ton of time — and I know it’s helping people to do that on the back end,” Dr. Hunter said.

On a personal note, it can be a challenge to address specifics to a patient when CMF symptoms and complexities are variable. “I think there are things I forget to mention in the room, and the education and follow-ups (impact) how patients are doing at multiple levels,” Dr. Hunter said.

His go-to refresher is the section on adverse effect management. Melissa Crawley, MD, at Texas Oncology at San Antonio Medical Center, gravitates to these guidelines as well. The oncologist-hematologist has extensive background in breast cancer, blood cancers, lung cancer and more.

PQIs are “great resources, especially for getting expertise in newer medications,” Dr. Crawley said.

“It just seems like there’s a new FDA approval once a week. We track all the toxicities and make sure the patients have access to the most up-to-date knowledge," she said.



MYELOFIBROSIS BACKGROUND

PRIMARY myelofibrosis occurs on its own and secondary myelofibrosis stems from a progression of other bone marrow diseases. Cytopenic myelofibrosis is more common among those with primary myelofibrosis.[3]

A rare, slow-moving, highly variable disease, myelofibrosis occurs when fibers build up inside the bone marrow, scarring the marrow and disrupting blood cell production. Myriad symptoms include fatigue, bone pain, easy bleeding and bruising. The spleen enlarges to produce more blood cells to compensate, a condition known as splenomegaly and characterized by abdominal discomfort.[1-4]

An estimated 13,000 to 18,500 people in the United States are living with the disease.[5]

Outcomes for MF diagnoses are based on risk factors: e.g., being 65 or older, having anemia, a high white blood cell count, 1% or more of cells in the blood being cancer cells, and more.[4-6] Patients who experience fever, night sweats, and weight loss are classed as having intermediate-2 risk disease. Patients with four or more risk factors are classed as high-risk.[4]

CYTOPENIC MYELOFIBROSIS CHALLENGES

CMF is characterized by lower blood counts (specifically anemia and thrombocytopenia), additional somatic mutations outside the Janus kinase/signal transducer and activator of transcription (JAK/STAT) pathway and a worse prognosis.[3]

These patients generally have more advanced disease, a greater risk of bleeding, a worse symptom burden, a higher risk of leukemic transformation, and shorter survival (a median 15 months).[2]

The FDA approved ruxolitinib in 2011 as the first JAK inhibitor for the treatment of myelofibrosis.[7]

The drug, shown to reduce spleen volume in the COMFORT-I and II studies, carries risks of worsening anemia and thrombocytopenia, limiting its use in CMF patients.[2, 8]

Indications/Mechanism

OF ACTION/RESEARCH

PACRITINIB (VONJO®) is an oral kinase inhibitor indicated for the treatment of adult patients with high-risk MF. The recommended dosage is 200 mg orally twice daily, taken with or without food.[7]

The 2024 National Comprehensive Cancer Network (NCCN) Guidelines recommend pacritinib for higher-risk MF patients — who are not transplant eligible — as first- or second-line treatment regardless of platelet count.[4]

The drug is the only preferred agent for patients with a platelet count < 50,000/uL.[7]

NCCN also recommends pacritinib in the management of MF-associated anemia in patients with or without splenomegaly and/or constitutional symptoms.[4]

Pacritinib is thought to work by blocking a mutated protein in bone marrow cells known as JAK2. Blocking this protein helps to decrease the formation of inflammatory cytokines responsible for such symptoms as an enlarged spleen, fatigue, low appetite, shortness of breath, weight loss, fever and more.[3, 7, 9, 10]

Pacritinib was approved based on efficacy in spleen volume reduction demonstrated in the PERSIST-2 trial.[2] This phase 3, randomized international multi-centered study compared pacritinib to best available therapy (BAT), which included any physician-selected treatment for MF (including ruxolitinib).[2, 9]

In this study, 311 patients were randomized 1:1:1 to pacritinib 400 mg once daily, pacritinib 200 mg twice daily, or BAT.[9-11]

Treatment with pacritinib twice daily led to significant improvements in spleen reduction, clinical improvement in hemoglobin, and reduction in transfusion burden.[7-11]

The most common adverse reactions in ≥20% of patients taking pacritinib 200 mg twice daily were diarrhea, thrombocytopenia, nausea, anemia, and peripheral edema.[7-11]

One of Dr. Taha's MF patients weighed just 95 pounds, but her abdomen was

Indications/Mechanism of Action/Research - continued

alarmingly swollen due to her enlarged spleen and liver.[3,6] "She goes, 'Doc, I feel like I'm seven months pregnant,'" the oncologist recalled.

After careful evaluation, he felt his patient was a good candidate for pacritinib, at the standard twice-daily dose of 200 mg. Her at-home therapy has noticeably improved her well-being. **"In the last six months, we've reduced her spleen size by 52%, according to her last scan," Dr. Taha said.**

A recent report predicts the use of pacritinib and momelotinib will expand, making the anticancer drugs backbones of future combinations with novel "disease-modifying agents."[12]

The PQI Process in Action with the MEDICALLY INTEGRATED PHARMACY

AS is the case with every drug – especially relatively new therapies – education is paramount. Members of the entire integrated medical team must be aware of the regimen, side effects and the importance of reporting patient-shared changes should adjustments be necessary.

A streamlined process and patient-involvement improve outcomes and quality of life.

Dr. Hunter works in close proximity with the pharmacy teams that support him and his patients. "We have two dedicated pharmacists for our leukemia group especially, and I always have one sitting in with me in clinic, which is very helpful," he said.

"I say, 'I want this drug,' and they make it happen, which is awesome," he said. "The pharmacists work with us, looking at drug interactions and dosing, and doing a great job with patient education."

Texas Oncology pharmacists view ongoing education as a reciprocally beneficial arrangement, Dr. Crawley praised.

"They always have the most up-to-date medication list. If there is a potential interaction, they're very helpful in pointing that out, so we need to consider a different therapy, a lower dose, or a dosing change in general," she said.

"The ability of our patients to be able to go directly to the pharmacy after they've completed their visit – and fill the most up-to-date prescription that they have – is really invaluable," she said.

All three practices follow PQI guidelines for new pacritinib scripts. The oncologist discusses the drug — including dosage, administration and side effects — with the patient and answers any questions.

A nurse and/or pharmacist follows up the same day, reviewing the information and providing take-home information. The patient's scripts, follow-ups, lab reports, side effects, questions (and provided medical advice) are entered into their EHR record for team review.

While ongoing communication allows for collaboration and coordinated care, it also expedites word of new drug therapies and clinical trials.

Erin Sypolt, RPh, PharmD, BCOP, exemplifies the role of pharmacist-educator at Florida Cancer Specialists & Research Institute. Beside overseeing 13 pharmacists, she briefs clinical and nonclinical staff on medical updates and advances.

"Education is my passion," the Clinical Pharmacist Supervisor said.

Time management is her superpower. Sypolt, a member of the Pharmacy & Therapeutics Committee, even devises at-a-glance briefings for clinicians with heavy schedules.

"I prepare educational slides on new drugs that come to market," Sypolt said.

SWITCHING FROM RUXOLITINIB TO PACRITINIB

An important consideration is how to define treatment failure or loss of response to ruxolitinib.

While no universally agreed-upon criteria exist, discussions often focus on inadequate spleen or symptom response within three months of treatment.[13]

While each institution may define "ruxolitinib failure" differently, identifying these patterns is essential for transitioning patients to alternative therapies when appropriate.

The PQI Process in Action with the Medically Integrated Pharmacy - continued

A modified Delphi panel reached consensus on what constitutes a treatment failure and included:[13]

• Patients with no improvement in symptoms or spleen response, or with progressive disease or ruxolitinib intolerance, following a maximally tolerated dose for ≥3 months; and
• Loss of spleen response ≥1 month following initial response (after ≥3 months of treatment).

Although recent clinical guidelines provide recommendations on withdrawing from ruxolitinib or fedratinib, there is no specific published data on how to transition a patient from approved JAK inhibitors used in myelofibrosis (ruxolitinib or fedratinib) to pacritinib.

Yet the strategy for switching patients from one JAK inhibitor to another should consider the mechanisms of action and pharmacokinetics of the drugs involved, as well as the patient's medical history and current clinical status.

Some practicing hematologists recommend the following approaches:[14-15]

• Gradually tapering off the current agent before starting a new one (e.g., reducing a ruxolitinib dose to 10 mg BID before switching).
• Using steroids during the transition to prevent symptom rebound;
• Ensuring close monitoring and safety management during the switch;
• Clear communication with the patient to manage expectations and provide a thorough understanding of the new drug.
• Immediate transition from one JAK inhibitor, particularly if on a lower dose of ruxolitinib (10 mg or less BID), to another with no gaps in treatment

The Florida pharmacy team is doubly vigilant when a patient transitions from ruxolitinib to pacritinib, taking the standard 200 mg dose twice daily.

"The team reviews the labs, discussing the dosage with the physician if the dosage varies from the twice-daily 200 mg," said colleague Taelor Kestner, PharmD, CSP.

"Counseling on the new medication, side effects, etc., follows. Patients receive an NCODA supportive care kit, too. "We also have a pharmacist available 24/7 to assist with after-hour calls," Kestner said.

KEEPING TEAMS IN SYNC

Emory Clinical Pharmacy Specialist Belinda Li, PharmD, BCOP, is in a unique position to track throughput.

Her cancer community spans in-person consults with inpatients and outpatients.

Li, who has extensive Hematology/Oncology experience, rotates every two months between clinics and hospitals. Her rounds naturally yield fresh information on conditions and treatments for EHRs.

"As the pharmacist, I'm either on rounds when I'm with inpatients and in the provider workroom, or with outpatients, clinics, and directly with the team," Li said. "But I'm actively and physically in clinic."

Every script is scrutinized, then electronically filed for authorization. The next step is a triage. For Emory pharmacy technician Caroline Prentice, CPhT, the goal is to secure authorization, "then I wrap and process it," she said. "I know when authorization is needed because I process the prescription."

Patients can reach out to an Emory specialty pharmacist for questions, who in turn brief clinical pharmacists, who follow up with patients. "We also often directly communicate with the providers about these adverse effects so that they're aware with any patient changes," Li said.

MIP staffers deploy the CoverMyMeds platform to expedite authorization and check for financial assistance for drugs via grants, coupons and copay card programs. The team handles and updates insurers via MyMed software.

Texan congeniality prevails at the efficient Texas Oncology-San Antonio Medical Center. Pharmacists, who dispatch prescriptions to patients in-person or electronically, are valued as detail-oriented colleagues. They navigate the insurance process, check with physicians and patients about refills and visits, and vigilant about safe, effective doses.

"Whenever a nurse turns in an order, the pharmacist usually is there, double-checking that the dose matches the patient's weight," said pharmacist manager Julio Quintanilla, PharmD.

For the on-site pharmacy, familiarity begets confidence and respect – and swift answers for anxious patients.

"If we have any questions about dose or anything, we're easily able to just either walk down to the doctor's office or give them a call and get all that worked out," Quintanilla said.

In turn, each member of the clinical team, made aware of toxicities, reports them to other health providers for assessment. Dosages can be reduced or held to manage side effects. (See chart in the next section on Adverse Effect Management.)

ADVERSE EFFECT MANAGEMENT

VONJO® contraindications include patient use of strong CYP3A4 inhibitors or inducers, which can significantly alter exposure to pacritinib and may increase adverse reactions or impair efficacy.[7] The drug may also affect fertility in males.[7]

As reported earlier, side effects include diarrhea, anemia, nausea and vomiting, and moderate, severe or life-threatening bleeding, and edema.

Patient input is essential, and the springboard to symptom management and quality of life, care providers agreed.

Dr. Crawley of Texas Oncology advocates candid, preemptive discussions before the patient starts on pacritinib. Her mindset: Be prepared.

"So, if they have treatment-related diarrhea, they'll have a remedy on hand. If they are having more than three to four bowel movements a day, I tell them to notify me and I'll start a second-line therapy," she said.

Clinical Pharmacy Specialist Li concurs. She ensures that patients have Imodium or another fast-acting antidiarrheal medication at home "just in case," she said. "I help them pick it up before they start on treatment.

"I always tell them that the diarrhea will get better over time," Li continued. "Two weeks is about the average duration. I'm kind of their cheerleader, to make sure they get through this time."

Bleeding, thrombosis swelling and drug-drug interactions require immediate attention. She makes sure patients know to alert pharmacists if they start any new medications or supplements. "They can always message us," Li said.

Refer to this chart to assess and manage adverse effects and how to modify dosage when indicated.

GENERAL DOSE REDUCTIONS[7]

- Initial starting dose: 200 mg twice daily
- First dose reduction: 100 mg twice daily
- Second dose reduction: 100 mg once daily
- Discontinue pacritinib if patient is unable to tolerate dose of 100 mg daily

Toxicity[7]	Management[7]	Dose Modifications[7]
New onset of diarrhea or change in frequency/consistency of bowel movement	• Initiate antidiarrheal medications • Encourage adequate oral hydration	• None for Grade 1 or 2
Grade 3 or 4 diarrhea	• Hold pacritinib until resolved to Grade 1 (< 4 stools/day over baseline) or lower/baseline • Intensify antidiarrheal regimen • Provide fluid replacement • Concomitant antidiarrheal treatment is required for patients restarting pacritinib	Restart at last given dose if resolved to Grade 1 • If diarrhea recurs, reduce dose 50% (once toxicity resolved)
Clinically significant worsening thrombocytopenia lasting more than 7 days	• Hold pacritinib until resolved	Reduce dose 50% (once resolved)
Moderate bleeding requiring intervention	• Hold pacritinib until resolved	Restart at last given dose (once resolved) • If hemorrhage recurs, reduce dose 50% (once resolved)
Severe bleeding requiring transfusion, invasive intervention or hospitalization	• Hold pacritinib until resolved	Reduce dose 50% (once resolved) • If hemorrhage recurs, discontinue pacritinib
Life-threatening bleeding requiring urgent intervention	• Discontinue pacritinib	
QTc prolongation >500 msec or >60 msec from baseline	• Hold pacritinib until QTc prolongation resolved to ≤480 msec or baseline within 1 week • Correct hypokalemia prior/during administration	Restart at last given dose if resolved within 1 week • If time to resolution > 1 week reduce dose (once resolved)

PATIENT-CENTERED ACTIVITIES

A diagnosis of chronic cancer is an emotional, physically draining ordeal. Yet a comprehensive, high-touch approach meaningfully engages patients on both clinical and personal levels. Patient support is essential to quality of life.

Open, ongoing communication facilitates care, hope and patient well-being. Patients "love having someone to speak to directly, and not have to go through hoops that you may have with an outside pharmacy," Emory pharmacy tech Prentice said.

"We have a lot of people who are older. Dealing with cancer, trying to triage and going through different steps to obtain information from an outside pharmacy hinders and frustrates them," she said.

"Having us here makes it a whole lot easier. They can talk to someone directly who knows their name. They're not a number in the system ... they know that people actually care."

NCODA not only provides physicians with guidelines, but provides free educational materials in English and Spanish. Free self-help tips and giveaways are also available to patients of NCODA members.

The more tip sheets and education for patients, the better, clinicians agreed.

"I'm all about the education," said Nina DiPierro, PharmD, BCOP, Clinical Oncology Pharmacist at Florida Cancer Specialists & Research Institute.

She helps assemble information kits for patients to take home, kits personalized with printed guides and reports detailing the latest news about each individual's oncology drug(s). Many handouts address side effect management, a major concern of patients.

Patients also know that their concerns and questions swiftly reach their doctors. "We are able to access the EHR, labs, and can communicate with providers directly," said Kestner, PharmD of Florida Cancer Specialists & Research Institute.

Dr. Crawley, of Texas Oncology, appreciates follow-ups and supplemental data that enhance treatment and outcomes. She is vigilant about postmarketing analysis — required or sponsor-approved studies that explore a medication's safety, efficacy and usage — so subsequent PQIs are a plus.

Deeper dives are essential for new drugs, "where postmarketing analysis is not quite complete," Dr. Crawley said.

New information is shared to staffs and patients and integrated into EHRs. MIP

Patient Resources Include:

- Oral Chemotherapy Education (Oce) Sheets (Printable)
- The Financial Assistance Tool (Printable)
- A Treatment Support Kit (Tsk) Containing:
  - A Treatment Booklet with OCE Sheet
  - A Treatment Calendar
  - Loperamide Hydrochloride Caplets (2 Mg X 24 Antidiarrheal Caplets)
  - Queasy Drops (Nausea Relief)
  - Weekly A.m./P.m. Pill Container
  - Water Bottle

Scan or click here to order a Pacritinib Treatment Support Kit

cornerstones include transparency and understanding.

"We want the patient to be at ease," Prentice said. "Each is a person. They could be a family member. Even after-hours, there's a person on call to answer any clinical questions, whether it's adverse effects, what have you."

"Each is a person. They could be a family member. Even after-hours, there's a person on call to answer any clinical questions, whether it's adverse effects, what have you. "

– Caroline Prentice, CPhT

Patients may forget specific details of clinical treatments, yet they remember how they are treated.

Her colleagues, from oncologists to support staff, are conscientious about updating EHRs, Sypolt said. All that documentation forms a complete picture of the individual, builds clinician-patient trust, and enhances respect, care and compliance.

"I know everything that's going on with that patient," she said.

"And when I'm reaching out to call the patient, it's like I'm reaching out to a friend, as opposed to a stranger on the other line."

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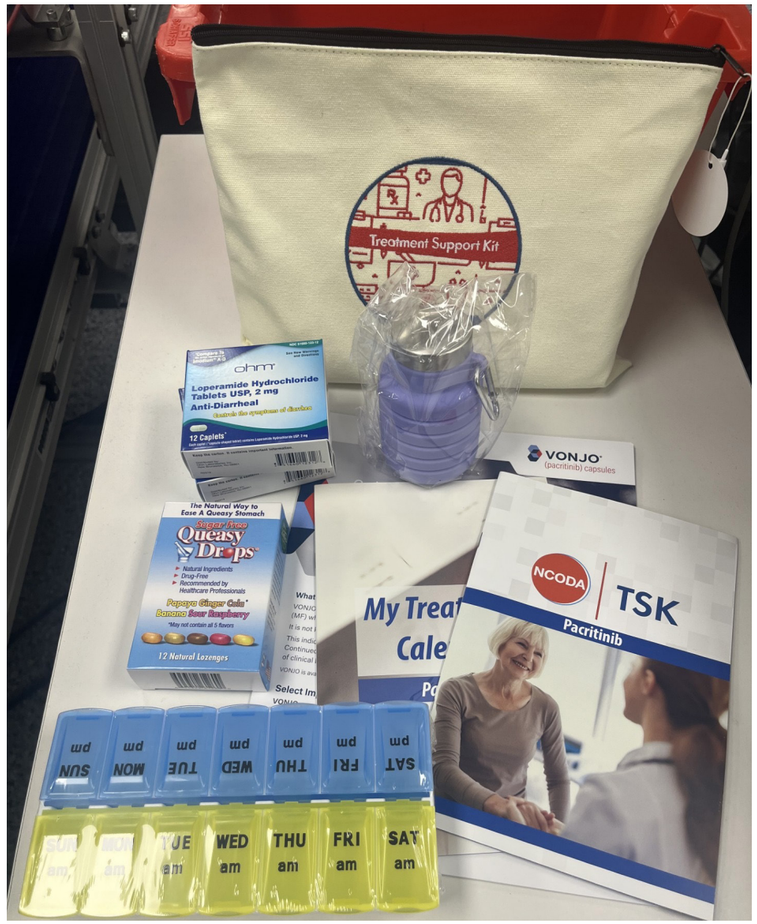

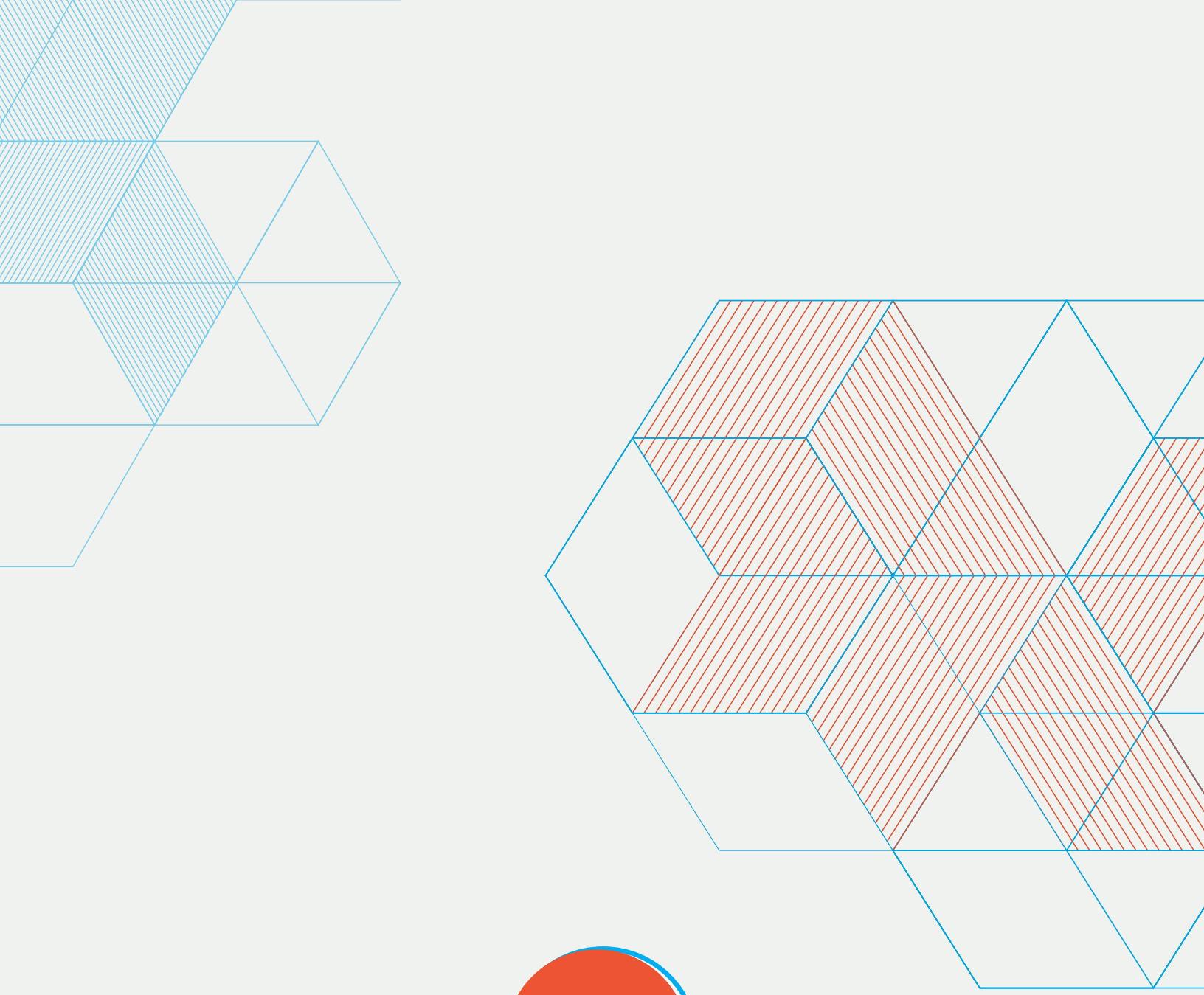

Practice panelist's comments reflect their experiences and opinions and should not be used as a substitute for medical judgment.