



## **REDEFINING ONCOLOGY DISTRIBUTION:**

Advancing Medically Integrated,  
Patient Centered Care Through  
Oncology Optimized Limited Distribution

The number of available oral anti-cancer medications has steadily increased over the past two decades, with oral medications playing a major role in the treatment of multiple tumor types.<sup>1</sup> Alongside this evolution, the medically integrated dispensing pharmacy (MIP) has become a best-in-class model for dispensing anti-cancer therapies while preserving a high standard of coordinated, patient centered care.

NCODA defines a MIP as a dispensing pharmacy within an oncology center of excellence that supports a patient-centered, multidisciplinary team approach.<sup>2</sup> This model enables real-time communication across the care team, improves access to anti-cancer therapies, and enhances outcomes by keeping treatment within the clinic's workflow. By integrating medication distribution directly into the oncology practice, MIPs streamline therapy initiation and monitoring, reduce treatment delays, and create a seamless experience for both patients and providers.<sup>3,4,5</sup>

While MIPs are well positioned to provide timely, coordinated care, their ability to dispense oral anti-cancer medications is often limited by how manufacturers choose to distribute their therapies.<sup>6,7</sup> In some cases, manufacturers may include PBM-affiliated mail-order specialty pharmacies (PBM-SPs)—those vertically integrated with large PBMs and payers—as part of their distribution network. This can prevent MIPs from filling prescriptions in-house, forcing patients to receive medications from external pharmacies that are disconnected from their care team.<sup>7</sup>

Limited distribution networks (LDNs) were originally intended to ensure clinical expertise and oversight of specialty medications,<sup>8</sup> but when PBM-SPs dominate these networks, it can disrupt continuity of care and delay therapy initiation. As more oral therapies come to market, the structure of these distribution networks plays an increasingly important role in the quality and coordination of cancer care.

This paper explores the interdependent relationship between the MIP and LDNs, highlighting how thoughtful distribution design can strengthen patient care and support optimal treatment outcomes. It also provides historical context for how these models have evolved and introduces updated terminology to bring clarity to the varying structures of LDNs across oncology.





## DEFINING MEDICALLY INTEGRATED PHARMACY (MIP)

A Medically Integrated Dispensing Pharmacy (MIP) is a dispensing pharmacy within an oncology center of excellence that promotes a patient-centered, multidisciplinary team approach.<sup>2</sup> By integrating dispensing directly into the clinic’s workflow, MIPs enable faster therapy initiation, streamlined communication, and more effective management of oral anti-cancer therapies.<sup>2</sup>

While MIPs may vary in structure—some operating as formal pharmacies and others through alternative dispensing models—the defining feature is their integration with the clinical care team. This model allows oncology practices to manage medication access directly, aligning pharmacy services with clinical decision-making to support better patient outcomes.

Unlike traditional specialty pharmacies—which often operate independently from the oncology care team—MIPs are embedded directly within the clinic. This integration allows for real-time collaboration across the care team, enabling streamlined access to medications, timely clinical interventions, and a more seamless experience for patients.

The differences between traditional mail-order specialty pharmacies and MIPs are especially clear when looking at the patient journey. In the MIP setting, patients are introduced to the care process early, often receiving medication counseling and insurance navigation at the time of their initial consultation. With full access to the electronic medical record (EMR), the MIP team can efficiently complete prior authorizations, verify clinical appropriateness, and offer personalized financial support. Throughout treatment, multiple care team members remain actively involved, monitoring and adjusting therapy based on real-time patient data.

External mail-order specialty pharmacies also provide important services but face limitations in accessing clinical information and coordinating with providers. This can result in delays in communication or therapy initiation, especially when mail-order delivery is the only fulfillment option.<sup>9</sup> Also, due to the operational flow of the prescription filling process, including time for delivery via mail, errant fills are increased, leading to waste and increase in cost to the overall healthcare system. In contrast, MIPs can offer more tailored delivery and education options that align with each patient’s unique needs and streamline the fulfillment process leading to increased cost avoidance and less waste.

### MIP/SP PATIENT JOURNEY MAP

PHASE 1	PHASE 2	PHASE 3	PHASE 4	PHASE 5	PHASE 6
Prescription issued by prescriber/initial consultation	Insurance Verification and Financial Counseling	Clinical Verification and Medication	Patient Education and Support	Medication Delivery	Ongoing Monitoring and Continuous Integrated Team Coordination
<ul style="list-style-type: none"> <li>▶ Oncologist*</li> <li>▶ APP*</li> <li>▶ Pharmacist</li> <li>▶ Nurse*</li> </ul>	<ul style="list-style-type: none"> <li>▶ Pharmacy Technicians</li> <li>▶ Financial Counselors</li> <li>▶ Social/Case Workers*</li> </ul>	<ul style="list-style-type: none"> <li>▶ Pharmacists in consultation with prescriber</li> </ul>	<ul style="list-style-type: none"> <li>▶ Oncologist/APP*</li> <li>▶ Pharmacist</li> <li>▶ Nurse*</li> <li>▶ Nurse Navigator*</li> </ul>	<ul style="list-style-type: none"> <li>▶ Pharmacist</li> <li>▶ Pharmacy Technicians</li> <li>▶ Nurses*</li> <li>▶ Courier/Delivery Staff</li> </ul>	<ul style="list-style-type: none"> <li>▶ The entire medically integrated care team</li> </ul>
<p><b>MIP:</b> Initial consult involves introduction to MID + expectations + initial medication counseling</p> <p><b>SP:</b> May be fragmented due to potential initial outreach hurdles</p>	<p><b>MIP:</b> Access to EMR and initial intake documents increases efficiency of PA process and Financial Navigation</p> <p><b>SP:</b> May be fragmented due to limited EMR access, and serving as middleman between practice and Insurance</p>	<p><b>MIP:</b> Clinical Pharmacists provide comprehensive chart workup due to access to EMR and patient records</p> <p><b>SP:</b> Clinical information may be based off pharmacy and insurance records, Limited EMR access represents a barrier to thorough clinical review</p>	<p><b>MIP:</b> Education typically provided before and during treatment by different members of the integrated care team</p> <p><b>SP:</b> Education typically provided at initiation and as needed per patient request</p>	<p><b>MIP:</b> Are typically flexible regarding medication delivery, and can tailor delivery needs to the specific patient</p> <p><b>SP:</b> If an SP does not have local options, mail order can be a barrier for some patients</p>	<p><b>MIP:</b> Multiple members of the integrated team participate in monitoring of patient on therapy often documented in the EMR</p> <p><b>SP:</b> Monitoring occurs; however, communication methods with integrated care team is fragmented</p>



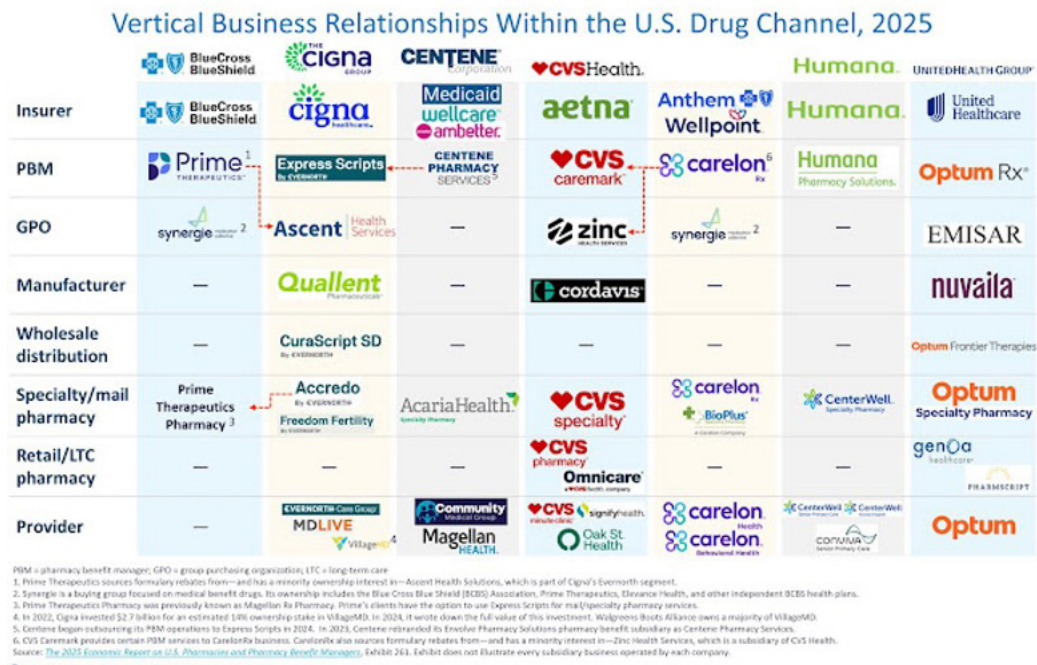
# MAIL-ORDER SPECIALTY PHARMACY MODELS AND THEIR RELATIONSHIP TO THE MIP

Mail-order specialty pharmacies play a vital role in supporting access to oncology therapies. However, the structure and alignment of these pharmacies can significantly influence how well they integrate with the clinical care team—and ultimately, how effectively they support the patient experience.

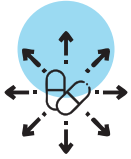
Some mail-order specialty pharmacies, such as Onco360 and Biologics by McKesson, operate independently of PBMs and maintain collaborative relationships with oncology practices. These organizations often work closely with MIPs, supporting seamless communication, efficient medication access, and continuity of care. Similarly, Prime Specialty Pharmacy—while affiliated with a PBM—has developed platforms like IntegratedRx that enable MIPs to remain closely involved in the dispensing process. In these models, patient choice is preserved, and care coordination remains strong.<sup>10</sup>

Other mail-order specialty pharmacies are part of large vertically integrated healthcare systems, where the pharmacy operates under the same ownership as a PBM or health plan (figure 1). In these arrangements, prescriptions are frequently routed through the PBM affiliated pharmacy by default, regardless of provider recommendation or patient preference. This process, often referred to as prescription steering, can limit the involvement of the oncology care team, delay therapy initiation, and contribute to fragmented care.<sup>11, 12</sup>

**FIGURE 1: VERTICAL INTEGRATION OF MAJOR U.S. HEALTHCARE COMPANIES. ADAPTED FROM FEIN AJ. DRUG CHANNELS. APRIL 9, 2025<sup>13</sup>**



The distinction lies not in PBM affiliation alone, but in whether the mail-order specialty pharmacy model allows for clinical collaboration, patient-centered flexibility, and alignment with the oncology care team. When MIPs are enabled to work alongside specialty pharmacy partners, the result is more coordinated care, more informed decision-making, and better support for patients throughout their treatment journey.



## LIMITED DISTRIBUTION NETWORKS (LDNs): BACKGROUND AND IMPACT

Limited Distribution Networks (LDNs) were originally developed to ensure safe and effective delivery of high-touch specialty medications. By partnering with a select group of pharmacies, manufacturers aimed to streamline handling, provide specialized clinical oversight, and improve patient support—particularly for therapies with complex storage, administration, or monitoring requirements.<sup>8</sup>

In recent years, increased consolidation across the healthcare landscape has led to increased vertical integration of mail-order specialty pharmacies with large PBMs and payers. While these changes may support operational alignment for some stakeholders, they have also contributed to a disruption of the original model benefit, creating distribution environment where patients are often steered toward PBM-affiliated specialty pharmacies (PBM-SPs), regardless of provider recommendation or patient preference. This can create challenges for MIPs, limiting their ability to dispense medications and maintain continuity of care within the integrated oncology setting.<sup>11,12</sup>

The way a distribution network is structured has a measurable impact on whether prescriptions are filled within the oncology clinic or diverted elsewhere. For patients treated within integrated oncology practices, the ability to fill prescriptions through their MIP supports stronger relationships, faster therapy starts, better adherence, reduced costs, and reduced fragmentation. In contrast, when prescriptions are routed through PBM-SPs, care coordination can be disrupted—slowing down access and limiting the oncology team’s involvement in managing the patient’s therapy.<sup>3,4,5,14</sup>

Data shows that the fewer PBM-SPs included in a network, the higher the prescription capture rate within the MIP. In networks that exclude these entities entirely, MIPs retain 98% of prescriptions across all payors (95% in commercial plans). That retention drops sharply as vertically integrated pharmacies are added: with one included, MIP capture falls to 79% (40% in commercial); with three or more, retention drops to just 58% (15% in commercial plans).<sup>14</sup>

**TABLE 1: PRESCRIPTION CAPTURE RATE BY NETWORK AND INSURANCE TYPE<sup>14</sup>**

PHARMACY NETWORK	PRESCRIPTION CAPTURE RATE (ALL PAYORS)	PRESCRIPTION CAPTURE RATE (COMMERCIAL ONLY)
No PBM-SP	98%	95%
1 PBM-SP	79%	40%
3+ PBM-SPs	58%	15%

The structure of the pharmacy network not only influences patient experience and access—it also has a direct impact on clinical and financial outcomes. When prescriptions are filled within the oncology practice, care teams can intervene more quickly, monitor adherence in real time, and make timely adjustments to therapy that leads to increased cost avoidance and less waste. This coordination leads to improved treatment continuity and greater patient satisfaction.<sup>15</sup>

Recent data further supports the value of integrated dispensing. A 2024 analysis by Prime Therapeutics found that patients who received oral oncolytics through integrated physician dispensing had significantly lower total costs of care compared to those using non-integrated dispensing channels. After adjusting for patient characteristics, integrated models demonstrated a reduction of \$5,379 in total healthcare spending and \$6,069 in medical benefit costs per patient. These findings highlight how integrated dispensing supports not only high-quality care, but also meaningful value across the healthcare system.<sup>16</sup>



## INTRODUCING CLEAR TERMINOLOGY FOR LIMITED DISTRIBUTION NETWORKS

While limited distribution networks (LDNs) have become a common part of oncology drug delivery, there is currently no standardized language to describe the various structures that exist. This lack of clarity can create confusion for providers, patients, and manufacturers alike—particularly as the number of oral anti-cancer therapies continues to grow.

To support greater clarity in distribution strategy and its impact on patient care, NCODA has introduced new terminology for describing Limited Distribution Networks (LDNs). These definitions are intended to standardize language across the oncology ecosystem, help providers assess their ability to retain prescriptions within the care team, and support meaningful dialogue with manufacturers about access and outcomes.

NCODA’s updated model includes three distinct categories based on the level of integration and the type of specialty pharmacies included in the network:

### LDN TERMINOLOGY TABLE

DISTRIBUTION MODEL	DEFINITION	PATIENT & MIP IMPACT	EXAMPLES
<b>Closed Distribution</b>	Medications available only through a highly restricted, manufacturer-designated network of specialty pharmacies, often due to REMS or special handling requirements.	Tightly controlled access; may exclude MIPs entirely. Can delay therapy initiation and fragment care; influence is limited due to regulatory safeguards.	Revlimid, Pomalyst, Thalomid
<b>Oncology Optimized Limited Distribution</b>	Networks that exclude vertically integrated PBM specialty pharmacies (PBM-SPs), supporting dispensing through MIPs and independent mail-order specialty pharmacies.	Enables high care coordination; 98% retention overall (95% commercial). Improves adherence, patient satisfaction, reduces waste and cost, and supports integrated care.	Onco360, Biologics by McKesson, Prime Specialty Pharmacy (via IntegratedRx)
<b>PBM-Influenced Limited Distribution</b>	Networks that include one or two vertically integrated PBM specialty pharmacies, often shaped by payer or PBM pressure.	Reduces MIP retention (LDD1: 79%/40% commercial; LDD3+: 58%/15% commercial); increases care fragmentation and therapy delays.	Accredo (Express Scripts), CVS Specialty (Caremark) and Optum Rx (UHC)

This revised terminology allows stakeholders to clearly distinguish between network designs and their clinical implications—ensuring that distribution decisions are better aligned with patient-first oncology care.



## ADVANCING A PATIENT-CENTERED APPROACH TO ONCOLOGY DISTRIBUTION

NCODA strongly supports the **Oncology Optimized Limited Distribution** model as the preferred standard for oral anti-cancer therapy access. By keeping prescriptions within the integrated oncology team setting and eliminating the influence of vertically integrated specialty pharmacies, this model enables the most coordinated, efficient, and patient-focused care. It reflects the core values of medically integrated dispensing and offers the clearest path to improving outcomes while preserving choice for both patients and providers.

NCODA recognizes that implementing a fully independent distribution model may not be feasible for all manufacturers. Market dynamics—including formulary restrictions, payer negotiations, and therapeutic area complexity—can introduce significant challenges. However, these realities do not diminish the importance of working toward a more transparent, patient-centered approach to drug distribution.

The Oncology Optimized Limited Distribution model represents a tangible step forward—one that prioritizes in-practice dispensing, fosters stronger patient-provider relationships, and supports high-quality, integrated care. Even incremental progress toward this model has a meaningful impact. As data has shown, limiting the number of vertically integrated specialty pharmacies in a distribution network improves prescription retention within the oncology clinic and leads to better adherence, improved patient satisfaction, lower costs, and improved outcomes.

We also recognize that healthcare is constantly evolving. In an ideal future, patient steerage would no longer be a barrier, and comprehensive policy solutions—such as pending PBM legislation—may fundamentally shift how access and distribution are managed. Should that landscape change, the need for terminology like this may diminish. But today, patients and providers need clarity. These definitions serve as a practical tool to evaluate access, communicate impact, and advocate for models that align with the best interests of those receiving care.

As an organization grounded in patient-centered and collaborative values, NCODA will continue to advocate for distribution models that reduce barriers to access and empower oncology teams to deliver the best possible care. We encourage pharmaceutical manufacturers, specialty pharmacy partners, and payers to join us in adopting terminology, tools, and practices that bring clarity to the distribution landscape—and ultimately, improve the cancer care journey for every patient.

**Together, we can advance a more ethical, transparent, and outcomes-driven future in oncology care.**



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