

FORUMREWIND

A LOOK BACK AT KEY SESSIONS FROM THE 2026 NCODA SPRING FORUM

ALIGNING INNOVATION, ACCESS AND CARE IN ONCOLOGY



**BISPECIFICS IN THE COMMUNITY:
FROM UNCERTAINTY TO CONFIDENCE**
PAGE 4

**MEDICARE CHANGES IN 2026:
WHAT IT MEANS FOR PATIENT ACCESS**
PAGE 5

**RIGHT TEST, RIGHT TIME,
BETTER LUNG CANCER DECISIONS**
PAGE 6



Professional Student Organization

Empowering The Future Generation of Oncology Leaders

Our focus is to offer an international community for healthcare students with a passion for oncology and the pharmaceutical industry. The NCODA Professional Student Organization (PSO) was established for students interested in oncology, association management, healthcare advocacy and policy, and industry leadership.

Opportunities That Shape Oncology Leaders

- First professional student organization of its kind
- Leadership and career development opportunities
- Access to international NCODA meetings
- Creation of educational materials impacting cancer care
- International publishing opportunities in *ForumRewind*, *SummitRewind*, *Inspire*, and *Oncolytics Today* publications
- Enhanced networking with oncology professionals, industry leaders, and key opinion leaders
- Oncology clinical practice experience and mentorship



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Being involved with NCODA has been a highlight of my pharmacy school experience! I have been able to enhance my leadership skills, confidence in public speaking and networking, mentorship skills and expand my knowledge of oncology pharmacy. Through being a part of NCODA, I have been given the opportunity to work with pharmacy professionals and students from around the world, which has been an amazing experience. I highly encourage other pharmacy students to join their school's PSO or, similar to myself, start their own chapter at their university!

-Melanie King
PharmD Candidate | Class of 2025
Memorial University, Newfoundland
NCODA PSO IEB President

”



LOCATIONS OF ESTABLISHED PSO CHAPTERS



FOR MORE INFORMATION OR TO SUGGEST NEW CHAPTERS:

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2026 NCODA INTERNATIONAL
SPRING FORUM

FORUMREWIND provides summaries of key sessions from NCODA's annual International Spring Forum written by members of NCODA's Professional Educators Network (PEN). To view slides from presentations, scan the QR code at the end of the summaries.

C O N T E N T S

4 | From Questions to Confidence: Bispecific T-cell Engagers in the Community

NCODA's Kelly Brunk reviews shifting step-up dosing of BTCEs from the inpatient to the outpatient setting.

4 | Leave No Veteran Behind: Expanding Access to Clinical Trials for Veteran Patients

A panel of veterans and healthcare professionals discuss the challenge of increasing participation of veteran patients.

5 | Bridging Coverage and Care in 2026: Medicare OOP Changes, M3P & Patient Financial Support

Panelists reveal how changes made to help reduce Medicare out-of-pocket expenses often confuses patients.

5 | Protecting Access to Oncology-Optimized Limited Distribution Drugs

A look at how OOLD models improve access, adherence and patient satisfaction.

6 | Right Test, Right Treatment, Right Time: Navigating Lung Cancer Diagnostics, Decisions & Supportive Care

A panel of nurses review the role of imaging, biopsy, pathology and NGS for staging and treatment of lung cancer.

7 | Polycythemia Vera in Modern Practice: Practical Treatment & Long-Term Management

Tania Jain, MD, discusses diagnosis and evaluation of PV, with a focus on risk stratification, symptom and treatment.

7 | The Biomarker Playbook: Understanding the Markers That Shape Access to Therapy

How biomarker testing directly influences both the selection of oncology treatments and patient access to therapy.

8 | Resilience and Well-Being for Oncology Clinicians

An examination of the role and the responsibility of clinician well-being in delivering high-quality oncology care.

8 | Evolving Treatment Paradigms in Bladder Cancer Across the Care Continuum

The session looks at rapid therapeutic expansion, shifting standards of care, toxicity management and patient selection.

9 | Leveraging Your Toolbox: Strategies for Navigating 2026 Barriers — Accumulators, Maximizers & Alternate Funding Programs

How cost management strategies often shift financial risk and administrative burden onto patients, practices and health systems.

10 | From Referral to Randomization: Using AI to Close Clinical Trial Enrollment Gaps

By scanning data across the electronic medical record, artificial intelligence-driven platforms can overcome common obstacles.

10 | Step Edits Unlocked: Strategies to Mitigate Impact & Improve Access in Oncology

Step edits are becoming a growing obstacle in oncology care and can create both clinical and administrative harm.

11 | Burnout in the Oncology Landscape: Challenges, Causes and Solutions

A look at the scope and impact of clinical burnout, and methods of coping with it.

11 | Recognize, Triage, Treat: A Practical Approach to ICI Toxicities

Managing the growing role of immune checkpoint inhibitors in cancer treatment.

FORUMREWIND

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From Questions to Confidence: Bispecific T-cell Engagers in the Community

PRESENTER: Kelly Brunk, PharmD, MBA, BCOP, Senior Manager of Clinical Excellence | NCODA

SYNOPSIS: Brunk reviewed the rationale and practical requirements for shifting step-up dosing (SUD) of bispecific T-cell engagers (BTCEs) from inpatient to outpatient settings.

PRESENTATION: BTCEs are engineered antibodies that bind tumor cells and activate T cells, triggering T-cell activation and tumor cell lysis. As of April 2026, 10 BTCEs are FDA-approved across various cancer indications.

SUD was traditionally delivered inpatient due to the risk of cytokine release syndrome (CRS). Recently, many centers have begun delivering SUD outpatient services because most CRS events during the SUD window are predictable and mild.

Outpatient SUD reduces inpatient days, time toxicity and system costs, preserves

scarce beds and expands access beyond tertiary centers, but it is appropriate only for selected patients. Common eligibility criteria include a reliable 24/7 caregiver, residence within ~1 hour of an admitting hospital, good performance status, controlled comorbidities, moderate tumor burden and low inflammatory markers.

Safe outpatient programs require a dedicated interprofessional team, formal risk stratification and validated monitoring schedules; objective escalation triggers using American Society for Transplantation and Cellular Therapy grading; Risk Evaluation and Mitigation Strategies compliance where applicable; immediate access to rescue medications; prebuilt electronic health record (EHR) order sets; and a direct admission pathway that bypasses the emergency department.

Attendees were divided into groups based on their profession to identify real-world barriers and practical solutions for delivering outpatient BTCEs SUD. Groups highlighted challenges, including staff turnover, hospital partnerships, 24/7 triage capacity, EHR alerts, pharmacy workflows and fear of

being first to adopt outpatient programs. Participants shared site-specific solutions, including resource binders, smart EHR phrases, annual competencies and medical alert bracelets with QR codes.

TAKEAWAY POINTS:

- Outpatient BTCE SUD can be performed safely in select patients, but it may not be appropriate for every center.
- Outpatient BTCE SUD requires strong leadership, standardized SOPs, robust hospital partnerships, ongoing training, and coordinated care pathways.

Summary by **Raye J. Mutcherson II**, PhD, PharmD, RPh, PGY1 Pharmacy Resident, Yale New Haven Hospital in New Haven, Connecticut. Reviewed by **Caitlyn Calso**, PharmDc (2026), University of Minnesota-Twin Cities, College of Pharmacy.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.



Leave No Veteran Behind: Expanding Access to Clinical Trials for Veteran Patients

MODERATOR: Patrick Krug, MA | Bristol Myers Squibb

PRESENTERS: Staff Sgt. Keni Thomas, Army Ranger, veteran; Jessica Garriss, BSN, RN, OCN | Ascension Seton in Austin, Texas; Lucio Gordan, MD | Florida Cancer Specialists and Research Institute (FCS); Rashi Romanoff, MHCPM, BS | National Association of Veterans' Research and Education Foundations (NAVREF); Edward Schuman, cancer survivor

SYNOPSIS: This combined session explored leadership, resilience and teamwork through military experience while also addressing disparities in oncology care and clinical trial access for veteran patients. Presenters highlighted how principles of leadership translate into healthcare practice and emphasized the need to improve awareness, coordination and access to clinical trials for veterans navigating complex care systems.

PRESENTATION: Thomas shared his experience during a mission in Mogadishu, Somalia,

as depicted in the film "Black Hawk Down." He emphasized that leadership is not defined by title but by example, captured in the phrase "Rangers lead the way." He said teamwork is essential to mission success and that a team is only as strong as its weakest link. Preparation and training allow teams to adapt when plans change, underscoring the belief that individuals perform as they are trained.

The panel discussion transitioned to challenges faced by veteran patients in oncology care. Despite more than 20 million veterans in the United States, only about 2% of veterans with cancer participate in clinical trials, which is significantly lower than national averages. Barriers include complex medical and mental health needs, social challenges, fragmented care across systems and difficulty navigating administrative processes. Romanoff described how NAVREF supports access to clinical trials by helping bridge gaps between the Veterans Affairs system and community practices. Gordan highlighted the FCS Valor Care program, which improves access and coordination while enhancing the patient experience through stronger community partnerships. Garriss emphasized the importance of nurse

navigators and interdisciplinary teams in supporting veterans, particularly in identifying eligible patients, coordinating care and advocating for their needs. Schuman shared how a second opinion led to his enrollment in an immunotherapy clinical trial after initially being recommended hospice care. The trip ultimately resulted in a positive outcome and survivorship.

TAKEAWAY POINTS:

- Leadership is defined by actions, accountability and the ability to empower others.
- Teams perform based on preparation, shared responsibility, and mutual support.
- Veteran patients face significant barriers to clinical trial access and coordinated care.

Summary by **Courtney Horn**, PharmD, Maryland Oncology Hematology, and **Brittini Disen**, RN, BSN, ONC, Oral Oncolytic Nurse Navigator, Lake Regional Health System. Reviewed by **L.B. Mason**, PharmDc (2027), University of Georgia.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.



Bridging Coverage and Care in 2026: Medicare OOP Changes, M3P & Patient Financial Support

PRESENTERS: Michael Heimall, President and CEO | HealthWell Foundation; Laura Beilke, Esq., Staff Attorney | Triage Cancer; Joan Martens, RPhT | American Oncology Network (AON)

SYNOPSIS: Financial toxicity remains a significant barrier to care for the senior population, particularly as the median income for those over age 65 sits below 300% of the Federal Poverty Level. This session examined financial assistance and affordability resources, with a focus on the Medicare Prescription Payment Plan (M3P) and its role in improving medication access. Participants identified actionable strategies for healthcare providers to support patients in navigating these programs to promote equitable outcomes.

PRESENTATION: As part of the Inflation Reduction Act, Medicare Part D structure was changed, and in 2025 the M3P was implemented. This optional program allows patients to spread out-of-pocket costs over

the calendar year through interest-free monthly installments, with the goal of improving affordability. While this may benefit patients without access to external funding, it can also be confusing to navigate.

The panel highlighted several challenges with the M3P program. First, patients with high upfront medication costs may benefit most. However, monthly payments can still be significant, particularly if enrollment occurs later in the year. Second, clear patient education is essential, as enrollment is optional but requires contacting the Medicare Part D plan and understanding ongoing payment obligations. Pharmacists and pharmacy technicians play a key role in early identification of appropriate patients and preventing delays in care. One example discussed involved a patient who entered the M3P and discontinued therapy after four months but remained responsible for ongoing payments, leading to confusion.

DISCUSSION:

Q: At what point in the workflow should teams identify patients who may need financial assistance, especially for high-cost oral therapies?

A: As soon as the copay is known, a team

member should engage the patient to discuss available options.

TAKEAWAY POINTS:

- While the Medicare Part D redesign improves structure and reduces out-of-pocket costs, it does not eliminate the need for financial assistance programs.
- M3P supports payment timing but does not lower total out-of-pocket costs.
- Confusion around benefits and costs persists, highlighting ongoing affordability challenges for oral oncology medications.
- Significant gaps remain in patient education around financial support options.

Summary by Jennifer M. Dix, CPhT, Pharmacy Concierge, Minnesota Oncology. Reviewed by Thomas Joseph Pena, PharmDc (2027), University of Texas at Austin, College of Pharmacy.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.



Protecting Access to Oncology-Optimized Limited Distribution Drugs

PRESENTERS: Douglas Braun, PharmD, CSP, CPH | NCODA; Jonas Congelli, RPh | NCODA; Kyle Kitchen, PharmD, MBA, Chief Clinical Officer | Utah Cancer Specialists; Ken Komorny, PharmD, Chief Pharmacy Officer | Moffitt Cancer Center

SYNOPSIS: This session highlighted the role of Medically Integrated Pharmacy (MIP) models in optimizing access to Oncology-Optimized Limited Distribution (OOLD) drugs. Presenters discussed how distribution models influence patient outcomes, addressed misconceptions surrounding limited distribution and emphasized strategies to reduce delays in therapy. The discussion reinforced that integrated care models improve coordination, adherence and overall oncology outcomes.

PRESENTATION: The presenters emphasized that the MIP model is central to high-quality oncology care, integrating pharmacists within the clinical team and enabling shared electronic medical record

access. This supports real-time collaboration, proactive monitoring and streamlined patient care, with pharmacists playing a critical role in optimizing therapy. Distribution models were reviewed, with OOLD identified as the NCODA-preferred approach because it minimizes pharmacy benefit manager restrictions and supports in-practice dispensing. A key misconception discussed was the concept of “open distribution,” as pharmacy benefit managers often impose hidden restrictions that limit true access, highlighting the need for broader OOLD education.

Real-world examples illustrated the clinical impact of delays, including a patient who waited two months for precision oncology therapy and passed away shortly after treatment initiation. In contrast, OOLD models enable coordinated efforts across care teams to address prior authorizations, financial assistance, and dispensing, reducing delays and improving access. Data showed that OOLD models achieve the highest prescription capture rates, while commercially insured patients are most affected by restrictive distribution models. Despite this, many practices report a substantial proportion of oral oncology prescriptions leaving their site.

Barriers to OOLD utilization include operational challenges, manufacturer alignment, electronic medical record limitations and limited awareness of distribution status. Strategies to address these barriers include leveraging NCODA resources, embedding OOLD options into clinical workflows, and actively challenging payer restrictions to maintain care within the MIP.

TAKEAWAY POINTS:

- Medically Integrated Pharmacy models enhance coordination, visibility and outcomes in oncology care.
- OOLD models improve access, adherence, and patient satisfaction.
- Pharmacy benefit manager restrictions contribute to delays that may negatively impact outcomes.

Summary by Krystal Monique Preston, PharmD, BCPS, Chicago Pharmacists Association. Reviewed by Coleman Zee, PharmDc (2027), The University of Texas at Austin, College of Pharmacy.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.



Right Test, Right Treatment, Right Time: Navigating Lung Cancer Diagnostics, Decisions and Supportive Care

PRESENTERS: Sarah Tangerini, FNP-BC | Dana-Farber Cancer Institute, and Jill Wines, RN, BSN | Minnesota Oncology

SYNOPSIS: Treatment for lung cancer begins at diagnosis and staging and includes the evolving role of biomarkers. A focus on the multidisciplinary team and the pivotal roles of nurses and navigators enhances patient experience and outcomes.

PRESENTATION: The presenters discussed the role of diagnostics, including appropriate imaging, biopsy, pathology, and next-generation sequencing (NGS) for accurate staging and treatment planning in lung cancer patients. A discussion of lung cancer subtypes and TNM staging was also presented. There was a special focus on identifying actionable driver mutations, including KRAS, EGFR, ALK and ROS1, prior to non-small cell lung cancer (NSCLC) treatment initiation. The presenters then reviewed chemotherapy and immunotherapy agents and expected

side effects and the importance of monitoring laboratory values for cytopenias and organ dysfunction for prompt intervention if abnormal. Finally, the presenters discussed the role of the nurse navigator in thoracic cancers. Nurse navigators are often the first line of contact for patients after diagnosis, and they help coordinate among multidisciplinary teams. Nurse navigators also provide patient education, facilitate clinical trials and promote early referral to palliative care to improve symptom control.

DISCUSSION:

Q: Do thoracic nurse navigators follow specific populations — non-small cell lung cancer (SCLC) vs NSCLC — or multiple populations?

A: Many thoracic nurse navigators follow with multiple populations, including SCLC, NSCLC and thymoma patients.

Q: For targeted therapies, is it possible to treat a patient first-line based on a KRAS mutation, or is chemoradiotherapy still first-line?

A: There are approved first-line treatments for EGFR mutations. However, for KRAS mutations, targeted therapies are still second-line treatment options.

Q: When discussing right follow-up, is it OK for a Stage 1 NSCLC patient who opted for surgery to follow strictly with the surgeon after resection and not also with medical oncology?

A: It is recommended that patients follow up with both the surgeon and the medical oncologist and continue restaging scans.

TAKEAWAY POINTS:

- Biomarker results in NSCLC, especially KRAS and PD-L1, are important to have prior to treatment initiation. In SCLC, the stage drives the treatment.
- Major treatment delays can happen due to insurance authorization, biomarker result turnaround time and coordination with other specialties.

Summary by **Apryl Moss**, DNP, APRN, FNP-C, Direct Care and Wellness, Florida. Reviewed by **Jiawei (David) Xue**, PharmDc (2027), Massachusetts College of Pharmacy and Health Sciences.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.



The PQI Podcast, presented by NCODA, hosts clinical and administrative experts in oncology providing insight on important industry topics and how they value the Positive Quality Intervention (PQI) resource for their practice. The podcast also highlights patient stories of hope, determination, and how patient-centered care impacts the cancer journey.

STREAMING NOW

Listen & follow along!

Polycythemia Vera in Modern Practice: Practical Treatment & Long-Term Management

PRESENTER: Tania Jain, MD | Johns Hopkins University

SYNOPSIS: Jain discussed the diagnosis and evaluation of polycythemia vera (PV), with a focus on risk stratification, symptom management and pharmacologic methods for PV treatment and disease modification.

PRESENTATION: PV is a myeloproliferative neoplasm with clonal expansion of hematopoietic stem and progenitor cells, resulting in elevated red blood cell mass. This is primarily a result of a chronically activated JAK-STAT signaling pathway. Jain provided an overview of the diagnosis, disease-related complications (including thrombosis), risk stratification, treatment goals, available treatment regimens and symptom management in PV.

Although PV treatment has primarily targeted preventing of thrombosis and decreasing symptoms, there has been a shift in focus to preventing disease transformation and progression.

Key clinical trials were discussed:

• **PROUD-PV and CONTINUATION-PV:** Ropeginterferon vs hydroxyurea – non-inferiority not met in PROUD-PV, complete hematologic response and improved disease burden at 36 months in CONTINUATION-PV.

• **MAJIC-PV:** Ruxolitinib vs best available therapy – complete response improved with ruxolitinib, overall survival did not differ, improved event-free survival with ruxolitinib and with complete response within 12 months.

• **Low PV:** Ropeginterferon + phlebotomy vs phlebotomy alone in low-risk PV patients – improved treatment response with ropeginterferon + phlebotomy.

Additional guidance was provided on assessing and managing symptoms in PV including non-pharmacologic and pharmacologic management of pruritus, headache/vasomotor symptoms and bone pain.

DISCUSSION:

Q: Can GLP-1 agonists provide improvement in PV symptoms?

A: More information is needed for GLP-1 agonists in PV. The anti-inflammatory nature

of GLP-1 agonists could provide improvement in MPN symptoms and offset weight gain seen with certain treatment regimens.

Q: Have you used pegylated interferon instead of ropeginterferon for PV?

A: Yes. There is data on use of either peginterferon or ropeginterferon for the management of PV. The toxicity profiles are similar, with ropeginterferon providing every other week dosing.

Q: Is there clinical consensus that lowering JAK2 allele burden reduced thrombosis?

A: Yes. Reduction in JAK2 allele burden can improve event-free survival (including thrombosis and progression of disease).

Summary by **Marie Sirek**, PharmD, BCACP, CPP, Clinical Pharmacy Specialist, Oral Oncology, Billings Clinic in Billings, Montana. Reviewed by **Marianna Hernandez**, PharmDc (2027), Massachusetts College of Pharmacy and Health Sciences.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.



The Biomarker Playbook: Understanding the Markers That Shape Access to Therapy

PRESENTERS: Sara Rentzel, CPhT, COPhT | American Oncology Network (AON); Jerry Mitchell, MD, MBA | Foundation Medicine

SYNOPSIS: This session examined how biomarker testing directly influences both the selection of oncology treatments and patient access to therapy. Presenters emphasized that many targeted treatments require confirmed biomarker results for payer approval, making accurate and complete documentation essential. They also reviewed where biomarker data are typically located within the medical record and highlighted the role of pharmacy technicians in preventing avoidable delays in care.

PRESENTATION: Rentzel explained that biomarkers now extend beyond guiding therapy selection. They are closely tied to guideline-based care, FDA labeling, and payer requirements. As a result, treatment access often depends on whether the correct biomarker result is clearly documented

before prior authorization submission. Missing or unclear documentation can create access barriers even when the prescribed therapy is clinically appropriate.

She emphasized that biomarker results are most often located in pathology or molecular testing reports rather than in progress notes, nursing documentation, or billing records. Team members involved in prior authorization should understand how to locate full reports within the electronic medical record, identify the specific biomarker required for the ordered therapy, and confirm that the documented mutation or expression aligns with the treatment plan.

The presenters also reviewed workflow barriers that commonly delay treatment initiation. These included reports not uploaded into the chart, results embedded within scanned documents, incomplete documentation, discrepancies between ordered therapy and biomarker findings, and delays due to pending test results. Case examples highlighted these challenges in patients receiving osimertinib, alectinib, and cetuximab, where missing EGFR confirmation, pending ALK results,

or unclear KRAS or NRAS status led to delays or denials.

TAKEAWAY POINTS:

- Biomarker confirmation is frequently required for both therapy selection and payer approval.
- Pathology and molecular testing reports are the primary sources for biomarker data.
- Missing, incomplete, or pending biomarker results can delay treatment initiation.
- Pharmacy technicians play a critical role in identifying and submitting accurate documentation.

Summary by **Stephanie Weightman**, PharmD, BCPS, BCPPS, BCEMP, Ambulatory Clinical Pharmacist, Regional One Health, Memphis. Reviewed by **Jefferson Zhong**, PharmDc (2027), University of Missouri-Kansas City.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.



Resilience and Well-Being for Oncology Clinicians

PRESENTERS: Michelle Kirschner, MSN, APRN | Cancer Survivorship Provider Network; Cathy Washburn, resilience coach and cancer survivor

SYNOPSIS: This session examined the role of clinician well-being in delivering high-quality oncology care. Presenters emphasized that resilience is closely tied to patient outcomes and addressed both systemic contributors to burnout and practical strategies to improve sustainability in practice. The session reinforced the importance of aligning personal well-being with professional responsibilities to maintain compassionate and effective care delivery.

PRESENTATION: Burnout was reframed as a system-driven issue rather than a personal limitation, influenced by competing demands such as productivity expectations and documentation burden. Lifestyle medicine was introduced as an evidence-based framework that supports both clinician and patient well-being through: nutrition, physical activity, sleep, stress management, avoidance of harmful

substances and social connection. The “Paving Wheel” model emphasized the need for balance across physical, emotional, and purpose-driven domains to sustain resilience over time.

Practical strategies included brief timeouts to regulate the nervous system, incorporating small variations into daily routines to support neuroplasticity, and managing energy across physical, emotional, cognitive and spiritual domains. Inner work was highlighted as a critical component of resilience, focusing on self-worth, emotional processing, including structured 90-second emotional resets, and nervous system regulation.

The presenters emphasized that meaningful change often begins with small, consistent practices that are reinforced through reflection, alignment with personal values and engagement in supportive professional communities.

DISCUSSION:

Participants discussed how to integrate resilience strategies into routine oncology workflows while navigating system-level constraints. Emphasis was placed on identifying realistic, sustainable approaches that can be

implemented in high-demand clinical environments and on strengthening team-based support to reinforce behavior change.

TAKEAWAY POINTS:

- Burnout is a system-driven issue that requires both structural change and individual strategies.
- Lifestyle medicine offers a practical, evidence-based framework for clinician well-being.
- Micro-practices and inner work support sustained resilience in oncology care.
- Small, consistent changes reinforced by community can lead to meaningful long-term impact.

Summary by **Caprina Tomlinson**, RN, OCN, RWJBarnabas Health. Reviewed by **Ray Woodall**, PharmDc (2027), Auburn University Harrison College of Pharmacy.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.



Evolving Treatment Paradigms in Bladder Cancer Across the Care Continuum

PRESENTER: Timothy Schieber, PharmD, MBA, Clinical Oncology Pharmacist | The University of Kansas Health System

SYNOPSIS: This session reviewed evolving treatment paradigms across the bladder cancer continuum, highlighting rapid therapeutic expansion, shifting standards of care and the increasing importance of toxicity management and patient selection.

PRESENTATION: Bladder cancer is the sixth most common malignancy in the U.S., with urothelial carcinoma comprising ~85% of cases. Management is stage dependent. In BCG-unresponsive non-muscle invasive disease, cystectomy remains standard but is often avoided due to morbidity. Bladder-sparing options now include gene therapy with nadofaragene firadenovec, nogapendekin alfa inbakicept (an interleukin-15 receptor agonist) plus BCG, and device-based gemcitabine delivery (TAR-200), all of which demonstrate improved response and recurrence-free survival vs

historical controls. Pembrolizumab remains an option but is less favored due to systemic toxicity.

In muscle-invasive disease, perioperative pembrolizumab plus enfortumab vedotin (EV) demonstrates significant improvements in event-free and overall survival compared to surgery alone, regardless of cisplatin eligibility, and is likely to become a new standard. In metastatic disease, EV plus pembrolizumab is now the preferred first-line regimen based on survival and tolerability compared with platinum-based regimens. Biomarker testing (HER2, FGFR) is critical for subsequent therapy selection, enabling the use of targeted agents such as trastuzumab deruxtecan and erdafitinib.

Subcutaneous immune checkpoint inhibitors improve administration efficiency without compromising efficacy. Toxicity management remains essential, particularly with EV combinations, which are associated with rash, neuropathy, and hyperglycemia. Proactive strategies, including early use of topical steroids and dose adjustments, improve tolerability.

DISCUSSION:

Q: Is there a role for immunotherapy in metastatic disease if previously used perioperatively?

A: A practical approach uses a six-month cutoff. If progression occurs ≥ 6 months after completion, rechallenge may be reasonable. Earlier progression suggests resistance, as drug levels may still be present.

Q: Is FISH testing acceptable for determining HER2 status?

A: FISH has limited utility for treatment selection. In practice, access may rely on broader documentation of HER2 positivity and trial-based justification rather than strict 2+ vs 3+ classification.

Summary by **Jana Ruediger**, PharmD, Clinical Pharmacist, Jefferson City, Missouri. Reviewed by **Caileigh Lavigne**, PharmD (2027), Belmont University College of Pharmacy.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.



Leveraging Your Toolbox: Strategies for Navigating 2026 Barriers-Accumulators, Maximizers & Alternate Funding Programs

PRESENTERS: Zach Waggoner, CPhT, BS, Medication Assistance Coordinator III | Yale New Haven Health; Christi Miller, BS, CRCR, Operational Manager Infusion Intake | Bon Secours Mercy Health in Greenville, S.C.

SYNOPSIS: This session explored the growing use of copay maximizers, copay accumulators and alternative funding programs (AFPs) and their implications for patient access and affordability.

PRESENTATION: Copay maximizers, copay accumulators and AFPs have a significant impact on patient affordability, access to therapy, and provider operations. While these benefit designs are often positioned as cost management strategies, they frequently shift financial risk and administrative burden away from payers and onto patients, pharmacies, infusion centers and health systems.

Copay maximizers adjust a patient's

monthly copay to align with the maximum manufacturer assistance available, effectively spreading assistance over time while preventing those dollars from applying toward the patient's deductible or out-of-pocket maximum. Patients may continue paying high costs despite "assistance," with no financial progress toward their true liability. Infusion centers are particularly disadvantaged, as medications are administered before billing occurs, often resulting in delayed and unexpected charges. Tracking total out-of-pocket responsibility is further complicated when infusions are bundled with other services.

Copay accumulators were described as more harmful. These programs apply manufacturer assistance upfront but exclude it entirely from deductible and out-of-pocket calculations. Once assistance is exhausted, patients face large, unexpected expenses and are often forced to choose between treatment continuation and financial stability. Most manufacturers do not support accumulator plans, leaving limited relief options. Patients frequently stop therapy, and frustration is directed at providers rather than payers. Hospitals and infusion centers

assume substantial risk, underscoring the importance of strong charity care programs and early financial assessment.

AFPs represent an even more disruptive approach, intentionally redirecting medication costs to third parties such as manufacturers, foundations, or international sourcing while excluding drugs from insurance coverage.

TAKEAWAY POINTS:

- Copay maximizers and accumulators often increase patient financial burden without reducing overall costs.
- Lack of upfront transparency leads to delayed treatment, financial shock, and loss of patient trust.

Summary by **Heather Maynard**, CPhT, COPHT, Pharmacy Business Operations Specialist, UW Health SwedishAmerican. Reviewed by **Coleman Zee**, PharmDc (2027), The University of Texas at Austin College of Pharmacy.

SESSION SLIDES: Scan the QR code at right to view slides from this presentation.



IMMUNOTHERAPY HUB

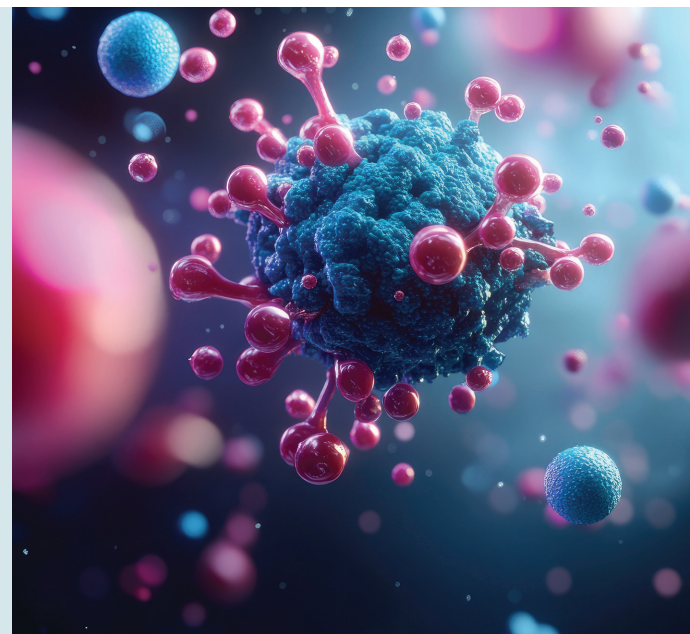
Implement Bispecific Therapies with Confidence & Clarity

The NCODA Immunotherapy Hub is your go-to source for everything related to bispecific T-cell engagers (BTCEs) – whether you're taking your first steps or you're refining advanced clinical workflows. Dive into curated, practice-ready content including foundational overviews, agent-specific insights, and downloadable SOPs from real practices.

Designed for oncologists, pharmacists, nurses, and care teams in community, and academic settings alike, the Hub equips you to navigate dosing schedules, understand REMS requirements, manage adverse reactions like CRS and neurotoxicity, and adapt procedures that truly fit your practice environment.



Visit [NCODA.org/Immunotherapy-Hub](https://www.ncoda.org/Immunotherapy-Hub) to access your immunotherapy roadmap now. Empower your team. Elevate patient care.



From Referral to Randomization: Using AI to Close Clinical Trial Enrollment Gaps

MODERATOR: Arturo Loaiza-Bonilla, MD, MSED | St. Luke's University Health Network, New Jersey

PRESENTERS: Katie Goodman, RN, Vice President Clinical Research | American Oncology Network; Caroline Merillat, Director of Clinical Research | Cancer Specialists of North Florida; Donald Harvey, PharmD, BCOP | Winship Cancer Institute of Emory University

SYNOPSIS: Artificial intelligence (AI) can address persistent barriers to clinical trial enrollment, particularly in community oncology settings. AI-enabled tools can identify eligible patients earlier, support interdisciplinary collaboration and reduce workflow inefficiencies from referral through randomization. It can help improve equity, accuracy and access with appropriate clinical oversight.

PRESENTATION: AI-driven platforms analyze structured and unstructured data within the electronic medical record to identify trial-eligible patients in real time.

These tools help overcome common obstacles, including complex eligibility criteria, fragmented clinical data and limited clinician bandwidth. AI can provide benefit by screening across entire networks, allowing both academic and community practices to match patients to trials more effectively and consistently. The importance of human validation, data security and clearly defined use cases when implementing AI was emphasized. AI can be a resource for clinicians by automating routine tasks, reducing documentation burden, and improving communication across care teams.

DISCUSSION:

Q: What safeguards are essential to ensure AI tools increase access and equity rather than unintentionally doing the opposite?

A: Trials should be available in the same communities where patients receive care to avoid widening disparities. Patients without reliable access to digital tools may be excluded if safeguards are not addressed. AI can help democratize trial access by consistently evaluating all patients in the system, rather than relying on individual providers. Strong data governance, security measures, and designated AI oversight are critical safeguards.

Q: What risks do organizations face if they do not modernize trial enrollment processes?

A: With much oncology research conducted outside the United States, delays in activation or enrolling create time and cost pressures with sponsors. Staffing limitations make it difficult to scale research without modernization, potentially threatening program sustainability. AI helps teams support more trials and patients using existing resources.

TAKEAWAY POINTS:

- AI can improve speed and accuracy of clinical trial patient identification.
- Thoughtful AI use can expand access and equity in clinical research.

Summary by Kelli Corona, PharmD, Pharmacy Fellow in Community Oncology, University of Florida and Cancer Specialists of North Florida. Reviewed by Beyonce Samuels, PharmDc (2028), Philadelphia College of Osteopathic Medicine-Georgia.

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Step Edits Unlocked: Strategies to Mitigate Impact & Improve Access in Oncology

MODERATOR: Jonas Congelli, RPH | NCODA

PRESENTERS: Kathy Oubre, MS | Ponchartrain Cancer Center; Manojkumar Bupathi, MD | Rocky Mountain Cancer Centers; Jonathan Hanke, PharmD | Cancer Care Specialists of Illinois

SYNOPSIS: Step edits, or step therapy, are a growing obstacle in oncology care. Although they are intended to control costs and encourage first-line treatments, they can delay effective treatment, increase risk of adverse effects, disrupt stable therapy and apply a one-size-fits-all approach to patients whose care requires individualization. Step therapy is not universally harmful and may be appropriate when it aligns with strong clinical evidence and includes clear, efficient exception processes; however, concern arises when rigid policies override individualized care.

PRESENTATION: The panelists largely agreed that step therapy carries a high risk

of downstream harm for patients. These prescribing restrictions are becoming more prevalent and labor-intensive for practices. Providers are increasingly unable to prescribe their preferred treatment first, which can delay care and trigger time-consuming appeal processes. Insurance-driven step edit pathways do not always account for the nuances of individual patients and treatment plans.

The increased prevalence of step edits has led to more denials, adding appeals to practice workflows. Recent data presented in the session showed that 75% of physicians report increased prior authorization denials and 93% report direct delays in care. The administrative burden is also substantial, with physicians and staff spending an average of 13 hours each week completing prior authorizations, and at least three employees are often involved in a single authorization.

Practices have started to preemptively address expected step requirements to obtain approval for the intended medication. The speakers also emphasized educating patients about step edits, especially during open enrollment, so patients understand

how benefit design may affect treatment timing and access. Clinicians should continue collecting data that demonstrate the harm of these policies to support legislative and policy change. Although around 80% of appealed denials are overturned, that correction still costs time and effort.

TAKEAWAY POINTS:

- Step edits are a growing concern in oncology and can create both clinical and administrative harm.
- Treatment decisions are nuanced, and rigid step edit policies may not reflect patient-specific needs.
- Step edits can delay care, contribute to treatment failure, increase side effects, and add stress for patients and practices.

Summary by Mitchel Ryan, RPH, Medication Therapy Management, M Health, Fairview, Minnesota. Reviewed by Bryce Beckstrom, PharmDc (2026), University of Texas at Austin.

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Burnout in the Oncology Landscape: Challenges, Causes and Solutions

PRESENTER: Fay J. Hlubocky, PhD, MA | University of Chicago Medicine

SYNOPSIS: Hlubocky examined the widespread scope and impact of burnout across the multidisciplinary oncology team, highlighting key contributing factors such as high emotional demand, heavy workloads and administrative burden, and how these challenges negatively affect patient safety, communication and workforce stability. She emphasized that burnout is a systemic issue requiring comprehensive, evidence-based solutions at the individual, team and organizational levels. Strategies discussed included fostering personal resilience, improving team collaboration and implementing system-wide changes to reduce inefficiencies and support clinicians.

PRESENTATION: Burnout in oncology is a widespread, chronic challenge driven by ongoing emotional strain, heavy workloads and administrative burden, affecting more than half of clinicians and worsening since

COVID-19. Marked by emotional exhaustion, depersonalization and a reduced sense of accomplishment, it impacts both personal well-being and patient care, while contributing to workforce loss. Key drivers include complex patient needs, exposure to suffering, limited autonomy and inefficient systems.

Hlubocky emphasized that burnout is measurable and should be routinely assessed using validated tools, with results informing targeted interventions. Meaningful change requires coordinated efforts across all levels of care delivery. Effective approaches include individual supports like mindfulness, cognitive behavioral strategies and peer connection. Team-based practices that strengthen communication and shared workload can help drive organizational changes that improve workflows and reduce strain.

She also highlighted the value of simple, intentional daily practices, such as brief mindfulness exercises, maintaining presence during patient interactions, and creating clear boundaries at the end of the workday. Ultimately, sustaining the oncology workforce depends on creating a supportive, collaborative culture that prioritizes clinician

well-being, fosters resilience and addresses the root causes of burnout.

DISCUSSION:

Q: How can we reduce burnout with limited staffing?

A: Focus on efficiency, streamline admin tasks, optimize workflows and delegate nonclinical work where possible.

TAKEAWAY POINTS:

- Oncology clinician wellness must be prioritized through regular assessment, ongoing education and access to mental health support.
- Team-based care models and multidisciplinary resilience efforts can improve collaboration and reduce stress.

Summary by **Kathleen Evans**, PharmD, Hematology Oncology Clinical Pharmacist Specialist, Endeavor Health Cancer Institute. Reviewed by **Lynn Cruz Lopategui**, PharmDc (2027), Larkin University.

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Recognize, Triage, Treat: A Practical Approach to ICI Toxicities

PRESENTER: Melissa Lechner, MD, PhD | UCLA Geffen School of Medicine

SYNOPSIS: This presentation outlines the growing role of immune checkpoint inhibitors (ICIs) in cancer treatment and the importance of managing immune-related adverse events (irAEs). ICIs enhance the immune system's ability to fight cancer but can also trigger autoimmune-like toxicities affecting multiple organ systems. These toxicities occur in over 60% of patients, with many requiring hospitalization or interruption of therapy. Early recognition and prompt management are essential to improving patient outcomes.

PRESENTATION: The most commonly affected organs include the skin, gastrointestinal tract and endocrine system, while more severe complications such as myocarditis, pneumonitis and hepatitis can be life-threatening. Studies show combination therapy increases the incidence of irAEs.

Management of irAEs begins with holding

immunotherapy and initiating corticosteroids and escalating to steroid-sparing immunosuppressive therapies when necessary. Endocrine irAEs are distinct in that they are permanent and typically require lifelong hormone replacement rather than high-dose steroid therapy.

A risk-based analysis should be considered prior to ICI therapy in patients with a pre-existing autoimmune disease. While these patients may be at increased risk for exacerbation, current evidence suggests they can still be treated safely with careful monitoring and informed decision-making. Data on genetic risk of irAEs is not yet validated for clinical practice. However, emerging data suggests a positive association between the development of irAEs and improved cancer outcomes, including longer overall and progression-free survival.

The use of multidisciplinary immune toxicity ("ITox") teams is highlighted as an effective strategy to improve care coordination, reduce hospital readmissions, and enhance clinical outcomes. The addition of in-services and standardized order sets ("smart sets") also serve as valuable clinical support tools.

DISCUSSION:

Q: For patients who develop ICI-induced diabetes, do they experience a complete loss of insulin production?

A: There is no "honeymoon period." Hyperglycemia typically develops within approximately three weeks. Most patients have an undetectable C-peptide early in the disease course, resulting in complete insulin dependence. Early continuous glucose monitoring is recommended.

TAKEAWAY POINTS:

- Immune-related toxicities from checkpoint inhibitors are more frequent and occur earlier with combination therapies.
- Endocrine irAEs are usually permanent and require prompt treatment.

Summary by **Rhondolyn Jones Smith**, PharmD, BCACP, MBA, Pharmacist, Ochsner Health, Georgia. Reviewed by **Lauren Ampadu**, PharmDc (2026), University of Connecticut.

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