

# ANCO FAX News

Association of Northern California Oncologists  
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## INTRODUCTION

The *ANCO FAX News* focuses on ANCO's core activities—advocacy, clinical and professional education, membership benefits, and *Association* news. While membership mailings, FAX broadcasts, and ListServ postings continue, the *ANCO FAX News* summarizes this information in a regular forum of important news to members. Contact the ANCO office for additional information regarding any item published in the *ANCO FAX News* or to contribute items.

The *ANCO FAX News* is sent to member practices (via FAX) and Corporate Member contacts (via e-mail). The next regular *ANCO FAX News* will be published on June 15<sup>th</sup>. Comments on and contributions to the *ANCO FAX News* are always welcome and encouraged at ANCO, P.O. Box 151109, San Rafael, CA 94915-1109; Voice: (415) 472-3960; FAX: (415) 472-3961; ExecDir@anco-online.org.

## ADVOCACY

[*Editor's Note:* ANCO meets regularly with national, regional, and statewide organizations to discuss issues of importance to hematology/oncology practices and people living with cancer. We continually seek input from members on agenda items for these meetings. Send your issues to the ANCO office.]

### *ACCC, ASCO, ASH, and National Legislative & Regulatory Issues*

[*Editor's Note:* ANCO is a member of the *Association of Community Cancer Centers* (ACCC) and a state/regional affiliate of the *American Society of Clinical Oncology* (ASCO).

ANCO and the *American Society of Hematology* (ASH) share information with members. We regularly participate with these organizations on matters of national importance to cancer care.]

**CMS's proposed national coverage policy for erythropoiesis stimulating agents (ESAs) for non-renal applications** would preempt current local (i.e., NHIC/Medicare) coverage policies. ANCO submitted the following comments on May 31<sup>st</sup>:

ANCO appreciates the opportunity to

**There is information in the  
ANCO FAX News  
for every member of your practice  
or organization.  
Pass it along!**

- Physician Members
- Nurses & Office Managers
- Office Staff
- Colleagues & Representatives

The *Association of Northern California Oncologists* (ANCO) is an association of hematologists/oncologists dedicated to promoting high professional standards of cancer care by providing a forum for the exchange of ideas, data, and knowledge. The material contained in the *ANCO FAX News* is intended as general information for ANCO members. Because diagnostic, treatment, contracting, coding, and billing decisions should be made on a case-by-case basis, any such information contained in the *ANCO FAX News* may not apply in any given situation. Members are encouraged to contact their own consultants or advisors to obtain specific advice on matters relating to contracting, coding, and billing. The information contained in the *ANCO FAX News* should not be used as a substitute for such advice.

comment on CMS's proposed national coverage policy on erythropoiesis stimulating agents (ESAs) for non-renal applications. Medical oncologists have successfully used ESAs for several years in the community setting to help prevent and treat anemia in people living with cancer. The benefits have outweighed the risks. We have not encountered the negative effects cited in CMS's coverage analysis. Millions of people living with cancer have received ESAs over the past two decades with little or no ill effects. In contrast, our experience is that ESAs allow cancer chemotherapy to continue on schedule and at full-dose, thereby maximizing the possibility of its fullest positive effect—improved response and survival. They also improve the quality of life of treated patients.

Generally, CMS's proposed national coverage policy on ESAs for non-renal applications has no scientific basis, and is in direct conflict with published scientific evidence, national practice guidelines, and expert opinion delivered during a meeting of the FDA's *Oncology Drug Advisory Committee* (ODAC). It does not follow national treatment guidelines promulgated by the *American Society of Clinical Oncology*, *American Society of Hematology*, or *National Comprehensive Cancer Network*. And, the proposed coverage policy, in response to recent negative clinical trials investigating ESAs at higher hemoglobin levels, inappropriately applies the results of those trials to a larger patient population.

Specifically, CMS proposes to not cover ESAs for the following conditions:

- *any anemia in cancer or cancer treatment patients due to folate deficiency, B-12 deficiency, hemolysis, bleeding, or bone marrow fibrosis.* ANCO objects to this non-coverage. While ESAs are not usually given to patients with some of these deficiencies, patients with marrow fibrosis may benefit from ESAs.
- *the anemia of myelodysplasia.* ANCO strenuously objects to this non-coverage.

All oncologists have seen patients with MDS that have shown improved hemoglobin with less transfusions and improved quality of life due to the use of ESAs. There is sufficient, high-level evidence that supports the use of ESAs for the treatment of anemia of myelodysplasia to make non-coverage inappropriate. This restriction effectively eliminates successful treatment options for these diagnoses. It is premature, will hurt patients, and will prove costly to the health care system.

- *the anemia of myeloid cancers and the anemia associated with the treatment of myeloid cancers or erythroid cancers.* Patients with myeloid cancers are often treated with anti-cancer drugs that interfere with red cell production, precisely the condition for which ESAs are used. In addition, there are no studies that have been done to differentiate the effectiveness of ESAs in treating chemotherapy-induced anemias based on the type of malignancy being treated. Therefore, ANCO objects to this non-coverage.
- *patients with treatment regimens including anti-angiogenic drugs such as Avastin (bevacizumab).* CMS is assuming that Avastin increases the risk of thrombotic events and that, therefore, ESAs are too risky to use with Avastin. ANCO can find no evidence for this assumption.
- *patients with treatment regimens including monoclonal/polyclonal antibodies directed against the epidermal growth factor (EGF) receptor (i.e., Erbitux and Vectibix).* ANCO finds no reason for this non-coverage in the scientific literature and does not understand its inclusion in the proposed coverage policy.
- *patients with thrombotic episodes related to malignancy.* Patients with thrombosis and anemia can receive effective treatment for their thrombosis and still benefit from the addition of ESAs. Again, there is no evidence to support this contraindication and this would

negatively impact a large group of patients.

ANCO also objects to some of CMS's coverage restrictions, as follows:

- CMS lists malignancies that will be covered for ESAs with some restrictions. Given that ESAs are primarily used to treat anemias resulting from the treatment of malignancies, it would make more sense to list those treatment protocols for which ESAs would be appropriate. Indeed, many standard of care treatment protocols achieve their maximum effectiveness through the use of ESAs to ensure optimal dosing and scheduling.

- *the hemoglobin/hematocrit levels immediately prior to initiation of dosing for the month should be < 9 g/dl or 27 percent in patients without known cardiovascular disease and < 10 g/dl or 30 percent in patients with documented symptomatic ischemic disease that cannot be treated with blood transfusion.* (CMS suggests that patients, especially those in the latter category, be alerted to the increased potential for thrombosis and sequelae.)

Cancer patients receiving chemotherapy do become symptomatic earlier than usual and achieve benefit with higher hemoglobin (for example, a hemoglobin between 9 and 10 in non cardiac patients). Therefore, ANCO objects to these initiation levels because they require anemic cancer patients to become symptomatic prior to the initiation of ESAs to treat their anemia, resulting in potential disruption in their anti-cancer treatment, and diminishing the potential success of their anti-cancer treatment. In addition, these initiation levels are too low given that there is a lag time before the effect of ESAs is realized. In other words, anemic cancer patients will become even more anemic before the effect of ESA treatment is felt. Finally, low initiation levels diminish the quality of life of people living with cancer receiving treatment.

- *the maximum covered 4 week treatment dose is 126,000 units for erythropoietin and*

*630 mcg for darbepoetin and continued use of the drug is not reasonable and necessary if there is evidence of poor drug response (hemoglobin/hematocrit rise < 1 g/dl or < 3%) after 4 weeks of treatment.* In general, ANCO objects to CMS coverage policy dictating dosing and duration. FDA, not CMS, via the package insert AND peer-reviewed published literature should dictate dosing and duration. Specifically, ANCO objects to these duration and dosing restrictions because many anemia inducing chemotherapy protocols last for more than 4 weeks. The only therapeutic option after 4 weeks will be to treat chemotherapy-induced anemia via transfusion—at less convenience to patient and provider, more risk to patient, and more cost to the system. In addition, CMS's proposed dosing is substantially lower than current professional treatment guidelines and is not based on any clinical evidence. Finally, the proposed draft also limits ESAs to a maximum of 12 weeks per year, which makes no sense if the patient will receive chemotherapy throughout the year or if treating MDS. In combination, these dosing and duration restrictions will increase the need for blood transfusions. ANCO is concerned that there is an insufficient blood supply to accommodate the additional need and that the increased costs to the health care system due to the transfusions and required ancillary medications will exceed the costs saved by restricting the use of ESAs.

In summary, ANCO is deeply concerned that CMS's proposal would set a dangerous precedent in which evidence-based standards of high quality care are ignored in setting national policy. Implementation of these provisions has the potential to inflict serious harm to the many cancer patients who rely on ESAs in the course of receiving treatment for their disease. Neither CMS nor local carriers would allow (i.e., reimburse) Medicare providers to treat cancer patients based on this type of scientific evidence or clinical

reasoning. It is clear that CMS's proposal is economically-driven, an invalid basis upon which to make clinical decisions. Using your terminology, the proposed national coverage policy is neither reasonable and it is unnecessary. It is also short-sighted in that it will result in additional suffering on the part of Medicare beneficiaries and cost to the system given the required additional blood transfusions and ancillary medical services needed to treat the additional severe anemias produced by the policy. ANCO proposes that ESAs be used according to current nationally-accepted treatment guidelines that have reduced chemotherapy-induced anemias, allowed for optimal cancer treatments, and improved quality of life amongst people living with cancer. Any restriction of these uses will harm patients and the health care system.

Physicians should note that *THE NOTICE PUBLISHED BY CMS IS A PROPOSAL. IT IS NOT CURRENT POLICY. THE USE OF ESAs SHOULD NOT BE GUIDED BY CMS'S PROPOSALS.* You can view the complete CMS proposal and ANCO encourages you to submit your comments at [www.cms.hhs.gov/mcd/viewdraftdecisionmemo.asp?id=203](http://www.cms.hhs.gov/mcd/viewdraftdecisionmemo.asp?id=203).

**CMS's Physician Quality Reporting Initiative (PQRI)** establishes a financial incentive for eligible professionals to participate in a voluntary quality-reporting program. Eligible professionals who successfully report a designated set of quality measures on claims for dates of service from July 1<sup>st</sup> to December 31<sup>st</sup>, 2007, may earn a lump sum bonus payment in early 2008, subject to a cap, of 1.5% of total allowed charges for covered Medicare physician fee schedule services. You do not need to enroll to participate in the program. You must report the appropriate quality measure data on claims using G-codes and/or CPT codes. For complete information on PQRI, including FAQs, visit [www.cms.hhs.gov/PQRI](http://www.cms.hhs.gov/PQRI). **CMS has designated G8300 as a test code for PQRI reporting prior to July 1<sup>st</sup>.** This code can be used to test readiness as follows:

1. Add the G8300 test code as a line item on any claims for services.

2. Randomly enter "\$0.00 or "\$0.01" as the line item charge for the test code.
3. Check your Remittance Advice (RA) for these claims to assure the test code has been passed through and processed by the carrier or MAC. You should see Claim Adjustment Reason Code message 96, "Non-covered charge(s)." Also, you will see Remittance Advice Remark Code message N365, "This procedure code is not payable. It is for reporting/information purposes only." The RA will serve as your feedback for the test. CMS will not issue any other feedback.
4. The RA will indicate that the test code was denied.

Eligible professionals are free to test until July 1<sup>st</sup>.

### ***CMA, MOASC, and State Legislative & Regulatory Issues***

*[Editor's Note: ANCO and the Medical Oncology Association of Southern California (MOASC) are members of the California Medical Association's (CMA) House of Delegates and Council on Legislation. ANCO and MOASC coordinate advocacy activities in California.]*

***Noteware Government Relations*** represents ANCO (and MOASC) in Sacramento. They report:

- Along with several other specialties and the CMA, ANCO supports AB1155. Under current law, if an HMO has underpaid, a penalty of 1 or 2 percent of the amount due can be assessed. This serves as a financial incentive for the HMOs to not pay the amount they owe, as it is cheaper to simply pay the fee. AB1155 would require the *Department of Managed Health Care* to assess a penalty fee equal to the amount due. The bill has passed out of *Assembly Health Committee* and awaits its final hearing in the *Assembly Appropriations Committee*.

**CMA and county medical societies are cohosting a series of seminars to help physician practices assess payor contracts and prepare for contract negotiations.** *Taking Charge* seminars are scheduled as follows:

- June 7-8<sup>th</sup>, Napa/Solano
- June 13<sup>th</sup>, Butte/Glen
- June 14<sup>th</sup>, North Valley (Chico)

Attendees will learn how to evaluate current and proposed payor contracts; target payors for contract termination, negotiation, or renegotiation; monitor payor compliance with contract terms; and, determine a payor's value to their practice. Participants will also receive a copy of CMA's payor contracting guide entitled *Taking Charge: Steps to Evaluating Relationships and Preparing for Negotiations*. Call/e-mail Jewel Thompson at (916) 551-2061/ [jthompson@cmanet.org](mailto:jthompson@cmanet.org) for more information.

### **NHIC/Medicare, DHS/MediCal, & Private Payors**

[Editor's Note: ANCO communicates regularly with *National Heritage Insurance Company* (NHIC) that administers Medicare in California and the *Department of Health Services* (DHS) that administers MediCal in California.]

On March 19<sup>th</sup>, CMS instructed NHIC/Medicare to continue to accept the Form CMS-1500 (12-90) version due to reports of an incorrectly printed version of the Form CMS-1500 (08-05) that was being sold by some print vendors. Providers will now be required to **begin submitting the Form CMS-1500 (08-05) only beginning July 2<sup>nd</sup>**. It is important to note that this requires the submission of the revised Form CMS-1500 paper claim form only, and has no bearing on the implementation of the *National Provider Identifier* (NPI) nor mandates the submission of the NPI by July 2<sup>nd</sup>.

**Health care providers are required by law to apply for a *National Provider Identifier* (NPI).** NPIs are being implemented as follows:

- Beginning May 23<sup>rd</sup>, systems will only accept an NPI.

At this point, any covered entity that is noncompliant, and has not implemented a contingency plan, is at risk for enforcement action. A tip sheet entitled *What the Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule Means for Health Care Providers* (available at [www.cms.hhs.gov/NationalProvIdentStand/Downloads/](http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/)

ContingencyTipSheet.pdf) advises the following:

1. Providers must have and use their NPI;
2. Clearinghouses must accept and use NPIs; and
3. Health plans must accept and send NPIs in claims transactions.

Providers should be:

1. Aware of contingency plans for any health plans they bill. Contingency plans may differ by health plan.
2. Aware that health plans may lift their contingency plans (and require an NPI on claims or other HIPAA transactions) any time before May 23<sup>rd</sup>, 2008.
3. Working with vendors and clearinghouses with whom they contract, to make sure the NPI is being passed to health plans.
4. Paying close attention to how and when health plans will be testing implementation of the NPI.
5. Aware that, for those health plans that did not establish a contingency plan, providers are required to use their NPIs now. This means that if you are not using your NPI, your claim may be rejected or denied.

For complete information, visit

[www.cms.hhs.gov/](http://www.cms.hhs.gov/)

NationalProvIdentStand. To apply for an NPI online, visit [nppes.cms.hhs.gov](http://nppes.cms.hhs.gov) or call the NPI enumerator to request a paper application at (800) 465-3203.

NHIC/Medicare urges all physicians and providers to obtain their NPI and begin using it. If you wish to test your EDI transmissions with the NPI, please contact the EDI Department at (213) 593-6950 or (530) 634-7024 and they will be happy to work with you.

The *Medicare B Resource* (June 2007) is available online at [www.medicarenhic.com/news/provider\\_news/mbr\\_jun07.pdf](http://www.medicarenhic.com/news/provider_news/mbr_jun07.pdf). Among the subjects discussed most relevant to hematology/oncology are:

- quarterly updates/revisions to Average Sales Price (ASP)

- quarterly updates to CCI edits
- updates to Remittance Advice Remark Codes and Claim Adjustment Reason Codes
- colorectal cancer screening
- claims processing for Competitive Acquisition Program (CAP)
- changes to the 2007 Medicare Physician Fee Schedule
- program overview for 2007 Physician Quality Reporting Initiative (PQRI)

**ANCO has communicated directly with *Blue Cross of California* and *Blue Shield of California* with regard to pre-service medical review of specialty drugs and preauthorization requirements for palonosetron, respectively. Specifically, with regard to pre-service medical review, ANCO wrote:**

ANCO members have brought the *Blue Cross of California* (BC) pre-service medical review of specialty drugs to our attention. ANCO understands that BC has implemented this policy to address the matter of potential misuse, overuse, and under use of these very expensive drugs occurring in its network. We further understand that BC will be doing retrospective review of claims to assure that the specialty drugs under review are used for their approved use and that the dose and duration of therapy are appropriate AND that your February 2<sup>nd</sup> letter advised BC providers that a voluntary pre-service review was available to assure them of approvable claims. In other words, BC is not implementing a mandatory pre-service medical review for these specialty drugs.

With regard to your original communication of this policy to providers:

First, our review of the February 2<sup>nd</sup> letter finds no use of the word "voluntary." Indeed, the voluntary nature of the program is only implied by your "offer[ing] pre-service medical review in an effort to speed payment to providers." ANCO suspects that most medical

oncology practices read your letter as an announcement of a mandatory pre-service medical review of specialty drugs. In addition, there is the further implication that if a provider does not participate in the pre-service medical review, that it will take longer to be reimbursed. ANCO suggests that if a practice subjects itself to a voluntary pre-service medical review of specific specialty drug utilization, then it should be reimbursed sooner. However, not participating in the voluntary program should not result in 1) delayed reimbursement, or 2) unnecessary medical review.

Second, the attachment to the February 2<sup>nd</sup> letter merely lists the specialty drugs that will be reviewed. It does not provide coverage policy for these drugs. It does not provide the acceptable uses for the specialty drugs or the additional coding/billing requirements. We can only assume these are provided on the BC website or other provider relations communications. It would have been helpful to have the acceptable uses for these specialty drugs included in the list.

Our members complain that preauthorization is an unwelcomed burden on delivering office chemotherapy and that it adds delay to treatment and requires additional office/management resources. On the other hand, some members welcome the assurance that preauthorization provides in terms of recovering the costs of expensive anti-cancer drugs.

Therefore, in the interest of maintaining high standards of quality cancer care within the confines of your voluntary pre-service medical review of specialty drugs policy and addressing the management issues identified by members, ANCO asks that:

1. Preauthorization requests for cancer treatment should be acted upon within 24 hours or the next business day.
2. Preauthorization requests for specialty drugs for their FDA-approved indications should be authorized without delay.

3. Preauthorization requests for off-label indications should be adjudicated pursuant to transparent policies. For example, the USP-DI or NCCN compendia should be accepted references. And, there should be a provision for an efficient and timely case-by-case determination for preauthorization requests based on peer-reviewed published literature.

4. Preauthorization requests for cancer treatments should include the anticipated length of treatment and that all approved preauthorizations of cancer treatments be for the entire period requested.

5. Certain supportive care drugs (e.g., G-CSF for neutropenic fever, anti-emetics) should be automatically approved for their first dose.

6. Given the additional work involved in requesting preauthorization for the use of the specified specialty drugs, the claims for reimbursing these drugs should be expedited and paid in an undisputed, prompt, and correct manner.

With regard to preauthorization requirements for palonosetron, ANCO wrote:

Several ANCO members have brought *Blue Shield of California's* new preauthorization requirements for palonosetron (Aloxi) to our attention. [We] are taking this opportunity to express our concerns with these new requirements. Our concerns are expressed in the interest of maintaining high standards of quality cancer care.

First, a question: Is this oral anti-emetic prerequisite for palonosetron only or for all IV anti-emetics? Is palonosetron being singled out due to its cost? With regard to cost, palonosetron is significantly distinguished from other IV anti-emetics by its prolonged protection. Therefore, its higher cost is recouped by negating the need for (and costs associated with) additional IV anti-emetics or oral anti-emetics and/or treatment of dehydration due to emesis.

Second, there is an economic and logistical burden associated with oral anti-emetics. Physicians and patients prefer IV anti-emetics due to their lower costs and easier accessibility. Physicians and patients often find it difficult to obtain even generic oral ondansetron and there are often requirements that a patient have tried and failed old school drugs like prochlorperazine and lorazepam before they will allow for an oral 5HT3 blocker to be prescribed. This approach does not make clinical sense (see our fourth and fifth points, below). Nausea and vomiting are very important quality of life issues for cancer patients and it would be a disservice to them to change current policy. Allowing physicians to administer IV anti-emetics eliminates the uncertainty of whether a patient has been able to obtain and take their anti-emetics, and also eliminates the issue of whether a patient being treated can actually absorb oral medications well since many patients already come in sick or have had prior GI surgery which reduces the efficacy of oral medications.

Third, while oral anti-emetics are equivalent to IV anti-emetics in some cases, there are highly emetogenic regimens that require IV anti-emetics immediately prior to their administration.

Fourth, it is well documented that allowing a patient to suffer symptoms of nausea or to vomit diminishes the possibility of controlling these side effects later on. Waiting to see if an oral anti-emetic fails prior to authorizing an effective IV anti-emetic runs counter to best clinical practice when there is a concern about emesis associated with treatment.

Fifth, there is no way to prospectively identify patients that will do well with an oral anti-emetic. It is not standard of care to use the less effective modality first.

## EDUCATION

[*Editor's Note:* ANCO organizes clinical and professional education meetings throughout the year and throughout Northern California.]

### ***Pay for Performance: Public (PQRI) & Private Payors***

ANCO, with the support of *AstraZeneca* and *Lash Group Healthcare Consultants*, is pleased to organize two talks for oncologists and oncology practice managers entitled *Pay for Performance: Public (PQRI) & Private Payors* with Harvey D. Bichkoff, MPH, *Chief Executive Officer, California Cancer Care*, and Gordon Hedrick, MHSA, *Manager, Field Reimbursement, Lash Group Healthcare Consultants*, on Tuesday, June 12<sup>th</sup> at 1PM at the Sacramento *Hyatt Regency*, and Thursday, June 14<sup>th</sup> at 9AM at the San José *Doubletree Hotel*. These meetings will summarize the general elements of a P4P program, tell you how to participate in Medicare's *Physician Quality Reporting Initiative (PQRI)*, and prepare your practice for P4P initiatives. Download the registration form at [www.anco-online.org/ancop4p.html](http://www.anco-online.org/ancop4p.html).

### ***ANCO 2007 Annual Meeting: Be Prepared!***

ANCO's *2007 Annual Meeting: Be Prepared!* will take place on Friday, June 29<sup>th</sup>-Saturday, June 30<sup>th</sup>, at the *Hyatt Vineyard Creek Hotel & Spa* in Santa Rosa. This meeting will provide participants with the tools and information to take on the management, technological, and clinical challenges facing oncology practice in the years to come. A meeting announcement (including agenda/faculty, housing information, and registration form) is available at [www.anco-online.org/annmtg2007.html](http://www.anco-online.org/annmtg2007.html).

### ***Washington Update: Legislative/Regulatory Impact on Oncology Practice***

ASCO's *Best of ASCO 2007* will take place on July 20<sup>th</sup>-21<sup>st</sup> at the *San Francisco Marriott*. *Best of ASCO* features premier abstracts from the *ASCO Annual Meeting* and offers CME opportunities for attendees. ANCO's *ASCO Highlights 2007* will not be organized in lieu of *Best of ASCO 2007* which we encourage all members to attend.

For additional information, visit [www.asco.org/boa2007](http://www.asco.org/boa2007). *Washington Update: Legislative/Regulatory Impact on Oncology Practice* with Joseph Bailes, M.D., will take place at *Best of ASCO* on the evening of July 19<sup>th</sup>. Plan on arriving early for *Best of ASCO* and attending the ANCO event. A meeting announcement and registration form is attached.

### ***Additional Education Meetings***

Other meetings of possible interest to ANCO member practices are:

June 9<sup>th</sup>  
*Living Now: A Survivor's Conference on Life after Transplant*  
National Marrow Donor Program  
San Francisco

June 19<sup>th</sup>  
*The 5<sup>th</sup> Annual Cancer Survivorship Series: Living With, Through, and Beyond Cancer*  
CancerCare  
Telephone Education Workshop

June 20<sup>th</sup>  
*Chemotherapy Related Anemia: Taking a Step Forward*  
CancerCare  
Telephone Education Workshop

June 21<sup>st</sup>  
*Breast Cancer Update from the ASCO 2007 Annual Meeting*  
CancerCare  
Telephone Education Workshop

June 24<sup>th</sup>-26<sup>th</sup>  
*8<sup>th</sup> Annual Patient Congress*  
Patient Advocate Foundation  
Washington, D.C.

June 26<sup>th</sup>  
*Medical Update on Head and Neck Cancer from the ASCO Annual Meeting*  
CancerCare  
Telephone Education Workshop

June 28<sup>th</sup>  
*Living with Colorectal Cancer*  
CancerCare  
Telephone Education Workshop

June 29<sup>th</sup>

*Living with Advanced Prostate Cancer: Update from the Annual Meeting of the American Society of Clinical Oncology (ASCO)*

CancerCare

Telephone Education Workshop

Please contact the ANCO office for more information about these meetings.

## MEMBERSHIP RESOURCES & BENEFITS

[Editor's Note: All ANCO members are also eligible for several tangible benefits.]

### Benefits

ANCO continues to seek ways to make membership more beneficial. The Board constantly identifies, reviews, and approves of additional membership benefits. In addition to the benefits derived from its advocacy, educational, and information dissemination activities, ANCO members may also benefit from several tangible benefits from a number of vendors, including:

- **California Oncology Consortium (COC) Group Purchasing Organization (GPO).** The COC GPO has preferred vendor agreements and discounted pricing with *International Oncology Network (ION)/Oncology Supply (OS)*, *McKesson Specialty Oncology Services* (formerly *National Oncology Alliance* or NOA), and OTN/Onmark. Contact your local ION/OS (Doug Storer at (650) 219-9282 or [douglas.storer@iononline.com](mailto:douglas.storer@iononline.com); or Paul Sullivan at (602) 391-9166 or [paul.sullivan@iononline.com](mailto:paul.sullivan@iononline.com)), McKesson/NOA (Scot Wagner at (866) 466-2462 or [swagner@noainc.com](mailto:swagner@noainc.com); or Patrick Walsh at (415) 793-8736 or [patrick.walsh@mckesson.com](mailto:patrick.walsh@mckesson.com)), or OTN/Onmark (Jennifer Semanik at (415) 497-2750 or Tony Policoni at (509) 995-0280 or [anthony.policoni@otnnet.com](mailto:anthony.policoni@otnnet.com); or Monique Weston at (650) 871-2108 or [monique.weston@onmarkservices.com](mailto:monique.weston@onmarkservices.com)) for more information.

- **IntrinsiQ's IntelliDose Discount Program** makes *IntelliDose*, a clinical oncology software solution. Contact Kris Beinder at *IntrinsiQ* directly at (800) 565-2279, x151 or [kbeinder@intrinsiq.com](mailto:kbeinder@intrinsiq.com) for more information about *IntrinsiQ Research* and *IntelliDose* or visit [www.intrinsiq.com](http://www.intrinsiq.com).

- **Oncology Pharmaceutical Services (OPS)**, a division of *US Oncology*. Contact Sean Taylor at (415) 235-4673 or [sean.taylor@usoncology.com](mailto:sean.taylor@usoncology.com) for more information.

ANCO and *McKesson Specialty Oncology Services* have agreed to make OncoEMR, an oncology-specific Web-based electronic medical record, available to ANCO members at a significant discount. An OncoEMR Web Demonstration will take place on June 13<sup>th</sup> at 1PM. To RSVP, please send e-mail with your name and your practice's name to [clay.cummings@mckesson.com](mailto:clay.cummings@mckesson.com) and type ANCO Demo in the subject line. For more information about OncoEMR, please contact your McKesson/NOA representative.

*Onmark* presents *Emerging Trends in Patients with MDS on June 21<sup>st</sup> and July 23<sup>rd</sup>*. Expert dialog on key considerations in the treatment of MDS in the community practice setting and a case study will be discussed by Guillermo Garcia-Manero, M.D. Topics will include updates on recently approved therapies for MDS, patient evaluation plan design, MDS therapeutic algorithm, and case studies. Enroll today for this informative clinical event at [onmarkevents.webex.com/onmarkevents](http://onmarkevents.webex.com/onmarkevents).

A replay of the *Introduction to OPS* webcast is available at [www.opspharmacist.com/ancowebcast](http://www.opspharmacist.com/ancowebcast).

## ASSOCIATION NEWS

### Individual Member News

*The ANCO Directory of Members 2006* was published and mailed to ANCO physician members; nurse and office manager contacts; and, Corporate Member representatives at the end of June 2006. Additional copies are available from

the ANCO office upon request. Please verify your *Directory* entry and contact the ANCO office with any corrections, additions, and/or deletions. The next *Directory* will be published in June 2007.

### ***Institutional Member News***

ANCO thanks the following **Institutional Members** for their support:

- *Stanford University Medical Oncology*
- *University of California, Davis, Cancer Center*
- *University of California, San Francisco*

For information on **continuing medical education meetings organized by our Institutional Members**, please visit:

- [med.stanford.edu/seminars/cme-all.jsp?qcme=on](http://med.stanford.edu/seminars/cme-all.jsp?qcme=on)
- [www.ucdmc.ucdavis.edu/cme/conferences](http://www.ucdmc.ucdavis.edu/cme/conferences)
- [www.cme.ucsf.edu/cme/index.aspx?Display=Date](http://www.cme.ucsf.edu/cme/index.aspx?Display=Date)

UCSF's *Pain Management and End-of-Life Care* takes place at the *Sir Francis Drake Hotel* in San Francisco on June 7-8<sup>th</sup>. Visit [www.cme.ucsf.edu/cme/CourseDetail.aspx?coursenumber=MDM07P14](http://www.cme.ucsf.edu/cme/CourseDetail.aspx?coursenumber=MDM07P14) for more information.

UCD's *8<sup>th</sup> Annual Advances in Oncology* takes place at the *Hyatt Regency* in Sacramento on October 20<sup>th</sup>.

The *9<sup>th</sup> Annual UCSF/UCD Thoracic Oncology Conference* takes place in San Francisco on November 17<sup>th</sup>. Visit [www.cme.ucsf.edu/cme/CourseDetail.aspx?coursenumber=MSU07004](http://www.cme.ucsf.edu/cme/CourseDetail.aspx?coursenumber=MSU07004) for more information.

### ***Corporate Member News***

ANCO thanks the following **Corporate Members** for their generous support that enables ANCO to provide services to the hematology/oncology community in Northern California, and to provide its members and their patients with substantial benefits in the areas of advocacy, education, and information dissemination:

*AMGEN • Abraxis Oncology • AstraZeneca  
Bayer Oncology/Onyx Pharmaceuticals  
biogenIDEC  
Bristol-Myers Squibb Oncology  
Cephalon Oncology • Clariant Diagnostics  
Enzon Pharmaceuticals  
Genentech BioOncology  
Genitope Corporation • Genomic Health  
Genzyme Oncology • GlaxoSmithKline  
International Oncology Network  
Lash Group Healthcare Consultants  
Lilly Oncology • Matrix Oncology  
McKesson Specialty Oncology Services  
MedImmune Oncology • MGI Pharma  
Millennium • Novartis Oncology  
Oncology Pharmaceutical Services  
Oncology Supply • Onmark  
Ortho Biotech • OSI Pharmaceuticals • OTN  
Pfizer Oncology • Pharmion  
Roche Oncology • Sanofi Aventis Oncology  
Schering-Plough Oncology • SuperGen*

We especially wish to thank and welcome *Genzyme Oncology* as new Corporate Member in 2007.

*Genentech BioOncology* informs ANCO that **DHS/MediCal will replace S0116 (Avastin, 10mg) with J9035 (Avastin, 5mg) on August 1<sup>st</sup>.**

*Pfizer Oncology* has informed ANCO that the **U.S. Food and Drug Administration approved Fragmin for the reduction of symptomatic venous thromboembolism (VTE) in patients with cancer.** Fragmin is a low molecular weight heparin initially approved in 1994.

*Roche Oncology* has informed ANCO that the **USP-DI/Thomson Micromedex recently published its acceptance of a new indication for Xeloda.** The USP-DI monograph for Xeloda has been revised to include gastric cancer, advanced/metastatic, as first-line therapy, as an approved off-label indication.