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INSIDE PMB

Pharmaceutical Management Branch

Cancer Therapy Evaluation Program
Division of Cancer Treatment and Diagnosis
National Cancer Institute
6130 Executive Blvd * Suite 7149
Rockville, Maryland 20852
Phone: (301) 496-5725
Order fax: (301) 480-4612 * Other fax: (301) 402-0429

THIS ISSUE'S THEME:

Pun©tu@t!on

The Exclamation Mark:
A Screamer
A Gasper
A Startler!

In the newspaper world, the exclamation mark is called a screamer, a gasper, or a startler. That pretty much sums up our reaction when we heard that some pharmacists have dispensed CTEP-supplied oral or take-home investigational agents with no pharmacy-prepared patient labels. Yes! You read that right! They just gave the investigational agent to the patient in the bottle or package the company packaged it in! [In the International Phonetic Alphabet, the exclamation mark is used as a letter indicating the postalveolar click—you know, that clicking sound you make when you place your tongue on the roof of your mouth forming a sucking vacuum, and snap it. More on this later.]

While pharmacy practice varies in different states, one thing should never vary—everything you dispense to a patient must have a prescription label on it! US federal law (21 CFR §201.100 and 21 USC §353) says prescription labels must include:

- the patient's name
- the prescribed dose
- directions for use
- dispenser's name and address
- prescription number
- date filled
- prescriber's name

Handing an unlabeled container of investigational agent to a patient is illegal, and defies good clinical practice. Dispense investigational drugs just like you dispense commercially available prescription drugs, or we will do more than just click at you in disgust!!!

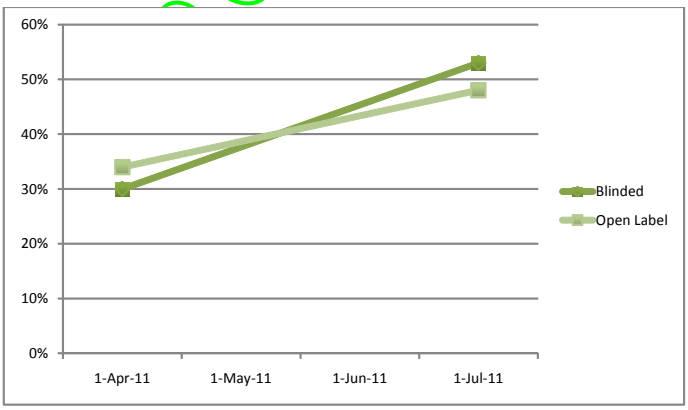
BAD !DEA

The Pomma Point

Not yet an everyday punctuation mark, the Pomma Point expresses that feeling of mild excitement that isn't quite exclamation point-ready. It's half way between the period and the exclamation point. That's how we feel about our progress on Online Agent Ordering Process (OAOP)

Why aren't you using OAOP?

Introduced in November 2010, sites are gradually shifting from manual (faxed) orders to OAOP. Its advantages include ease of use, e-mail confirmation that your order has been received, shipping information and priority processing in the event of an unanticipated government closing.



Proportion of Clinical Drugs Requests Arriving via OAOP

Find OAOP at
https://wapps-ctep.nci.nih.gov/OAOP/pages/login.jspx
The Training Guide will tell you how to get started

Period. The End.

When you return agents to the NCI Clinical Repository, please provide complete, accurate information on the NCI Return Drug List so we can account for the drug and you can fly through audits. Common errors include:

•Forgetting to include the Return Drug List form with the shipment
•Returning non-NCI-supplied agents, non-CTEP-supplied agents or returning agent lots never distributed by the NCI
•Recording lot numbers or quantities that do not match items contained in the shipment
•Referencing an incorrect NCI-designated protocol number
•Omitting the complete investigator name (first and last name) and NCI investigator number
•Omitting your institution name and address
•Using the wrong return form or incorrect version of the form

The information we capture in our database is only as good as the information you provide.

Please populate all information blocks on the form, and review it for completeness and accuracy before returning the shipment to the NCI Clinical Repository.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health
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The Slash:
Indicating Choice

In regular old writing (and maybe in IM, too), the slash is used to indicate a choice between the words it separates. Some people, for example, interchange the terms dangerous goods and hazardous drugs. They think dangerous goods/hazardous drugs are the same. They are wrong/incorrect.

- The Department of Transportation (DOT) classifies dangerous goods and requires specialized packaging and shipping. (Not packing/shipping, because a "/" means "or." Packing AND shipping. A dangerous goods designation determines how an agent must be packed and shipped.)
- The National Institute of Occupational Safety and Health (NIOSH) classifies drugs/pharmaceuticals as hazardous if they may increase health risks when released into the environment. This has more to do with the agent's classification, mechanism of action and specific formulation. Hazardous classification determines how an agent must be handled and how it must be disposed of.

To find out if a drug is a DG, check the Material Safety Data Sheet (MSDS). If your facility is a DG-approved shipper, you can return a DG to the NCI repository. If not, you must ask PMB for approval for local destruction. CTEP-supplied DG agents include ixabepilone, temsirolimus and dasatinib.

To find out if a drug is hazardous, refer to the 2004 NIOSH publication, "Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings—Worker Employer Recommendations" http://tinyurl.com/3p5saf3. Find the link directing you to a recent list of antineoplastic/hazardous drugs encountered in healthcare settings. NIOSH updates this list periodically and includes only commercially-available agents. The NIOSH publication also provides current recommendations on preventing exposure in the pharmacy.

There is an art to asking questions:

- Where do you look?
- Who do you ask?
- What do you ask?
- What information should you have before asking a question?

Let's think about this…

If you have agent-related questions, the first place to visit is the protocol. Unquestionably, you must review the treatment plan and agent information sections.

For procedural questions, try the PMB section of the CTEP web site: ctep.cancer.gov (remember, no www.). On the web site you'll find forms, information on our online agent order process (OAOP), and a set of frequently asked questions.

Still can't find what you need? It's time to contact us, either at (301) 496-5725 or PMBAfterHours@mail.nih.gov.

This brings us to:

- What information should I have before contacting PMB? For questions involving investigational agents, have the NSC # handy. You're aware that an agent has several names during its lifetime—fortunately, the NSC # remains unchanged forever, and ever, and ever…
- In addition, please have any other information pertinent to your question. For example:

"I found 3 vials of study drug on a back shelf. Are they still good?" In order to answer this question, we'll need the NSC #, the strength if it comes in multiple strengths, and lot number(s).

"A bottle of capsules were inadvertently put in the refrigerator, can we dispense it?" How long was the bottle in the refrigerator? What was the temperature range during that period? What is the NSC #?

"I have an order to administer study agent at twice the concentration listed in the protocol. Can we do this?" In addition to the NSC #s and protocol #s, we'll need to know the desired concentration and the potential diluents.

Remember, the only stupid ? is an unasked ?!

#$%^##&*!!! How did that happen?!?!?!?!?

Sites are reporting a particular type of error more often: errors that occur because the pharmacy's computer system is programmed to calculate doses based on the product's concentration. Then the manufacturer changes the concentration, but the clinical sites fail to update their computer.

Alert all staff involved in pharmaceutical ordering and checking processes to be careful when drug concentrations change. If the drug dose has been programmed into your computer, double check to be sure that automatic dosing formulas in all software reflects the new concentration. And be sure to mark vials brightly as "old" and "new" formulation until you use all old formulation.

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Where Is It @?

When you need an investigator brochure, where do you find it?

PMB posts a list of IBs currently available from us @ http://ctep.cancer.gov/branches/pmb/default.htm

If CTEP holds the IND for and distributes the agent, ask the IB Coordinator @ PMB @ ibcoordinator@mail.nih.gov.

- For these protocols, please do not request the IB from the company or the cooperative group. (We have to track who gets the IB.)
- Our company collaborators consider IB information confidential. We can only release IBs to registered, active investigators associated with an approved LOI, concept, or protocol.

PMB sometimes holds an IND for and distributes agents that have already been marketed for other indications. The collaborator doesn't always maintain an IB, especially years after FDA approval.

- If we have an IB, the IB Coordinator is the person to contact.
- When we don't, please use the complete prescribing information (AKA package insert) as the primary source of information in addition to information contained in the protocol.

PMB occasionally distributes commercially marketed agents on specific trials to facilitate conduct of the trial. We do not sponsor or hold the IND for these agents. An IB may (or may not) be available for the agent.

- If an IB is available, PMB will not provide it. The protocol document should provide direction for obtaining a copy.
- If an IB is not available, use the complete prescribing information as the primary source of information for the agent (e.g., for IRB submissions).

Brackets, Brackets Everywhere

A bracket is used to clarify something that isn't normally part of the sentence. Instead of overwhelming you with bracketted text, we're using this sidebar to give you additional information about lenalidomide-related issues.

•To establish a CTEP Identity and Access Management (IAM) account, access IAM from the PMB page on the CTEP web site: http://ctep.cancer.gov/branches/pmb/associate_registration.htm or directly via the URL https://eapps-ctep.nci.nih.gov/iam/.

You'll need to fax your registration form (because it has all of the information we need) and your training certificate when you receive it.
•Groups and BMT CTN, please use CTSU Operations Office (fax # 1-888-691-8039-for questions, please contact the CTSU Help Desk at 1-888-823-5923)
•If you are using lenalidomide on protocol AMC-070, AMC uses its coordinating office (fax # 240-238-2842 Attn: AMC Regulatory Specialist)
•For all other protocols, please use PMB (fax # 301-402-0429 Attn: LCP)

Δ Can Be Difficult: Still Have Lenalidomide Questions?

The Δ isn't really a punctuation mark. We use it so often to mean "change," however, it's like a kissing cousin to punctuation marks. Most of you may know by now that PMB has Δ'd from investigationally-labeled lenalidomide capsules in a bunch of bottle sizes to 100-count commercial bottles. This means you need to repackage the capsules into a pharmacy vial providing only a 28-day supply or one cycle, whichever is shorter. Consider counting capsules instead of bottles on the DARF to make inventory tracking easier!

Δ's to Celgene's Lenalidomide Counselor Program (LCP) are throwing some of you for a loop (and we have solutions). Here's what we've heard many of you say:

1. I haven't gotten training notification from Celgene and it's been over a week since I sent in my registration. (Answer: Please be patient and do not re-fax your registration. Celgene is batching registrations and if you don't hear back within two weeks of faxing your registration, e-mail coop_ma@celgene.com. Ask them to confirm they received it and when they will send your link to the training.)

2. I took lenalidomide training a year ago. Can I use this certificate? (Answer: No, the requirements have Δ'd and you need to repeat the training for 2011.)

3. What is CTEPpersonID? (Answer: This is your IAM account personal ID. If you don't have an IAM account, you need to get one to participate on any lenalidomide cooperative group trial [see the sidebar]. PMB recommends all ordering designees have an IAM account for accessing OAOP [see page 1].)

4. Where should I fax my registration form and training certificate? (Answer: For all cooperative group trials, send them to the CTSU [see the sidebar]; for AMC-070, send them to the coordinating office; for all other protocols, send them to PMB [see the bracketed sidebar].)

NOTICE:

All clinical sites that dispense PMB-distributed lenalidomide must have two registered counseling clinicians before August 15, 2011.
If you are on the CTSU, you can find information on their web site. If not, please refer to the protocol amendment documentation we sent dated May 3, 2011. Or call PMB!

You Have to Have a Point to Have a Point

In April 2004, The Joint Commission placed trailing zeroes on its DO NOT USE list.

- Trailing zeroes are the 0s to the right of a decimal point at the very end of a number's decimal representation. No other digits follow, and the trailing zeroes don't affect the number's value. So they have no point unless you are indicating the number of significant figures in a measurement.
- The Joint Commission promotes use of leading zeroes, however. Leading zeroes occur before (to the left of) a decimal point. They are placeholders, hinting that there is a decimal point in the number.

It's dangerous to use trailing zeroes (e.g., 7.0 vs 7) or a leading decimal point without a leading zero (e.g. .4 instead of 0.4) when writing orders for drugs and biologics. People who read and transcribe these orders may not see the decimal point in handwritten orders that have trailing zeroes or no leading zeros. What's the point? Misinterpretation of such orders could cause a 10-fold dosing error,

Please remember that trailing zeroes have no point in term's of a dose's value. Leading zeroes do–they signal that a decimal point is coming at you.

You have to have a point to have a point. Please stop using trailing zeroes, and embrace leading zeroes.

Speaking of Colons:

Colorectal cancer is the third most common type of cancer and the second leading cause of cancer death in the United States according to the U.S. Preventive Service Task Force (USPTF). Colorectal cancer screening detects cancer; polyps; nonpolypoid lesions; and other growths. Although nonpolypoid lesions occur less often than polyps do, they can develop into malignancies. Early screening prevents colon cancer and leads to early treatment of the disease.

Several methods are used for colorectal cancer screening:

- The most common and frequently used is the conventional colonoscopy. It uses a colonoscope to examine the entire colon and the rectum. A gastroenterologist inserts the lighted device into the anus and wiggles it up to the end of the colon. This procedure also allows the operator to remove any polyps or perform a biopsy during the exam. Patients are usually sedated. Adverse events (which are rare) may include perforation, bleeding, severe abdominal pain, diverticulitis, or cardiovascular events.
- Virtual colonoscopy or a computerized tomographic colonography is used primarily to photograph the colon and rectum and create detailed images of polyps or other abnormalities. This procedure is less invasive than conventional colonoscopy; thus, patients are not sedated during the test.

Other screening tests include fecal occult blood test (FOBT), sigmoidoscopy, double contrast barium enema (DCBE), and digital rectal exam (DRE).

- FOBT tests for blood hidden in stool. There are two types of FOBT—a guaiac FOBT and an immunochemical FOBT. The guaiac FOBT detects heme in stool. The immunochemical FOBT uses antibodies to detect human hemoglobin protein.
- Sigmoidoscopy is used to detect precancerous and cancerous growths in the rectum and lower colon that can be removed or biopsied when applicable.
- Double contrast barium enema (DCBE) is a series of x-rays of the entire colon and rectum. It requires patients to take enema with a barium solution, and air is introduced into the colon before taking the x-ray.
- Digital rectal exam (DRE) only examines the lower part of the rectum . A health care provider inserts a lubricated, gloved finger into the rectum to feel for abnormality of the rectum.

Studies support colorectal cancer screening for early detection and treatment of colon cancer. As the result, the USPTF recommends colonoscopy screening in adults at age 50 years up to 75 years old. The organization does not support routine screening for colorectal cancer in adults age 76 to 85 years, and definitely does not recommend the test for those who are >85 years old.

Be sure to promote " : " screening!

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