Evaluating the Impact of Oncology Optimized Limited Distribution on Access to Oral Oncology Therapies

A City of Hope Integrated Pharmacy Model Analysis

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Executive Summary

Pharmacy distribution models can influence how efficiently patients access oral oncology therapies and how effectively medically integrated oncology teams coordinate care. City of Hope has developed a highly integrated oncology pharmacy infrastructure designed to address these challenges. The system combines medically integrated pharmacies, specialty pharmacy services, and national mail-order capabilities to support patients receiving oral oncology therapies.

To evaluate how distribution models influence dispensing performance, City of Hope analyzed real-world prescription activity for three oral therapies used in later-line metastatic colorectal cancer (mCRC): fruquintinib (FRUZAQLA®), trifluridine/tipiracil (Lonsurf®), and regorafenib (Stivarga®). All analyses reflect prescription activity captured within the City of Hope integrated pharmacy network, representing therapies dispensed through internal channels.

Fruquintinib is distributed through the NCODA Oncology Optimized Limited Distribution (OOLD) framework, which includes oncology-focused medically integrated pharmacies within the dispensing network and enables prescriptions to be filled within the City of Hope integrated pharmacy system. Trifluridine/tipiracil and regorafenib are distributed through an open distribution network, where pharmacy benefit manager requirements (PMBs) may direct dispensing to external pharmacies, thus limiting internal capture within the integrated pharmacy model.

Key findings from the analysis include:

- Higher capture rate for fruquintinib (77.4%) compared with trifluridine/tipiracil (53.3%) and regorafenib (49.4%)
- Higher fill rate for fruquintinib (81.1%) compared with trifluridine/tipiracil (56.9%) and regorafenib (67.4%)
- Higher patient retention for fruquintinib (67.2%) compared with trifluridine/tipiracil (58.4%) and regorafenib (33.3%)
- Average time to fill of approximately 4 days for fruquintinib, comparable to trifluridine/tipiracil (3 days) and shorter than regorafenib (9 days)

These findings suggest that distribution models, incorporating oncology-focused medically integrated pharmacies, may support stronger care coordination between prescribing providers and pharmacy teams. The City of Hope experience highlights how integrated oncology pharmacy infrastructure, combined with an OOLD distribution model, improves operational efficiency, medication access, and continuity of care for patients receiving oral oncology therapies. When thoughtfully designed distribution models enable integrated oncology pharmacy care, patients gain faster, more coordinated access to therapy, demonstrating how purposeful distribution can directly translate into better real-world care.

Introduction

Oral oncology therapies have become an integral component of modern cancer care, with targeted agents expanding treatment options beyond traditional cytotoxic chemotherapy. As the use of oral oncology medications continues to expand, pharmacy access models and drug distribution strategies play a critical role in determining how efficiently patients receive therapy and how effectively care teams can support adherence and continuity of care.[1]

Limited distribution is one approach used by manufacturers to manage the dispensing of specialty medications. In these programs, distribution is restricted to a select network of pharmacies in order to support specialized patient management, enable clinical oversight, and facilitate coordinated communication between prescribers and dispensing pharmacies. While limited distribution networks can support specialized care delivery, they may also influence operational factors such as time to fill, pharmacy capture rates, adherence, and treatment continuation, that ultimately shape the patient treatment experience. [2]

To address these considerations in oncology, NCODA developed the Oncology Optimized Limited Distribution (OOLD) framework. The OOLD model aims to ensure that limited distribution networks include oncology-focused pharmacies embedded within cancer care teams, such as medically integrated dispensing pharmacies within oncology practices and health systems. By incorporating these clinically integrated pharmacies into distribution networks, the OOLD approach seeks to strengthen care coordination, improve patient access to therapy, and enhance the quality of oncology pharmacy services.[3]

Fruquintinib represents an example of an oral oncology therapy distributed through an OOLD network. Other therapies commonly used in later-line mCRC, including regorafenib and trifluridine/tipiracil, are distributed through an open distribution network. While medically integrated oncology pharmacies may have dispensing access, PBM-driven routing requirements can prevent them from retaining prescriptions and disrupt continuous, coordinated patient care. As a result, differences in distribution models may influence the proportion of dispensing activity captured within the City of Hope integrated pharmacy network. These therapies

therefore provide a useful comparison for examining how distribution design may impact real-world dispensing and patient access within an integrated oncology care setting.[3,4]

To explore these questions, City of Hope, one of the largest and most advanced dedicated cancer research and treatment organizations in the United States, conducted an evaluation of dispensing activity across its integrated oncology pharmacy infrastructure. This analysis examines how distribution strategy and pharmacy integration influence operational and patient-centered metrics. In oncology, distribution is not just a delivery mechanism, it is a strategic lever that determines whether innovative therapies can reach patients through coordinated, patient-centered care.

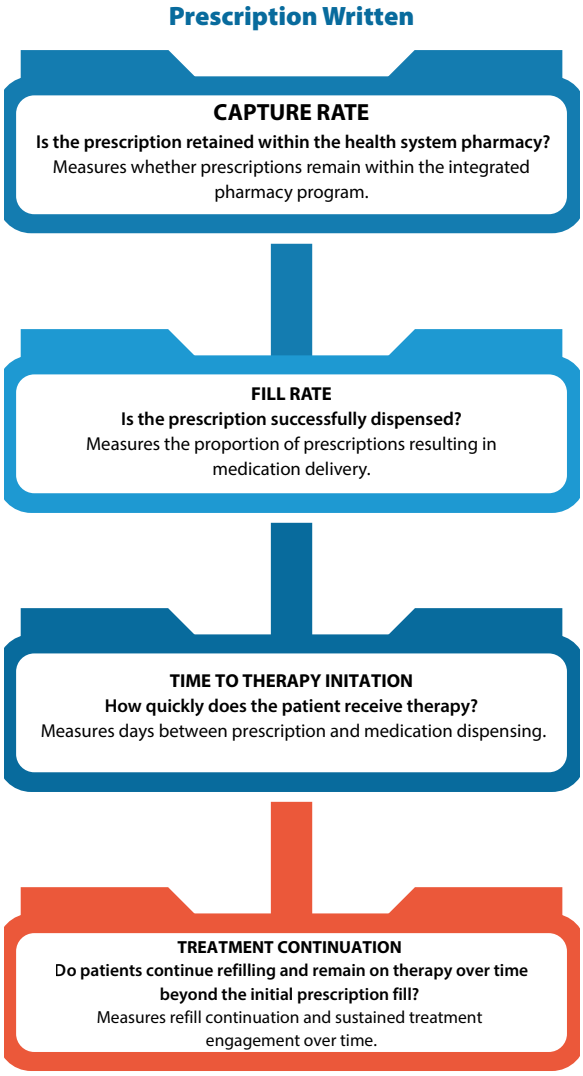


Figure 1. Oral Oncology Medication Access and Treatment Continuum.

Operational metrics evaluated in this analysis represent sequential stages of the oral oncology therapy access continuum. The continuum begins with prescription routing within the health system (capture rate), progresses through successful medication dispensing (fill rate) and time to therapy initiation, and extends to ongoing treatment engagement as reflected by patient retention and continued therapy over time.

City of Hope Integrated Oncology Pharmacy Model

City of Hope's oncology pharmacy network supports patients across a national system of regional campuses and affiliated clinical locations, including the National Medical Center in Duarte, CA and regional networks serving the Los Angeles area, Orange County (CA), Phoenix, Atlanta, and Chicago. This integrated network allows the health system to maintain continuity of pharmacy services regardless of where patients receive care within the City of Hope system, promoting a uniform patient experience, a high level of service, and patient equity.

Within this model, City of Hope pharmacies are positioned to dispense all eligible prescriptions generated within the system; however, payer mandates, network restrictions, or distribution limitations may require a meaningful portion of prescriptions to be filled externally.

If payer restrictions or geographic considerations prevent dispensing at a specific location, prescriptions can be routed seamlessly to another City of Hope pharmacy capable of servicing the patient. This flexibility allows pharmacy teams to maintain oversight of medication access even when distribution constraints arise.

To support this approach, City of Hope has developed a coordinated oncology pharmacy infrastructure designed to manage oral oncology therapies across multiple care settings. The system integrates three complementary platforms:

- medically integrated pharmacies embedded within oncology clinics
- hospital-based specialty pharmacies
- a national oncology mail-order pharmacy

Together, these components function as a unified, concierge-like model, enabling pharmacy teams to manage therapy from prescription initiation through ongoing treatment, while preserving continuity across the care continuum.

A defining feature of the model is a centralized triage workflow for all oral oncolytic prescriptions. Once a prescription is written, pharmacy teams promptly initiate benefits investigation, prior authorization, and financial assistance screening. This proactive coordination allows the team to determine the most appropriate dispensing pathway and address common access barriers, including financial toxicity, before engaging the patient.

This proactive, comprehensive approach ensures that patients receive a single, clear communication outlining how they will obtain their medication, including where it will be filled, the status of insurance approval, and what

their out-of-pocket cost will be, along with any available financial assistance options. By addressing administrative complexity early in the process, the pharmacy team helps ensure that the prescription process does not become an additional burden during cancer treatment

Before prescriptions are transmitted externally, pharmacy teams perform extensive coordination and a clinical evaluation, including:

- verification of dosing accuracy
- benefits investigation and prior authorization initiation
- identification of financial assistance programs
- communication of necessary documentation to external pharmacies when required
- review of therapeutic appropriateness and safety

This preparation helps ensure that external pharmacies can process and dispense medications efficiently without requiring additional clarification or administrative follow-up. City of Hope provides this service without reimbursement, while the PBM that steered the prescription to its wholly owned mail-order pharmacy receives the reimbursement and benefits from City of Hope's proactive, patient-centered efforts.

Addressing Access and Affordability

Financial barriers remain one of the most common challenges affecting patient access to oral oncology therapies. To address this issue, City of Hope pharmacy teams utilize a structured financial navigation process that evaluates multiple affordability pathways including:

- manufacturer co-pay assistance programs
- independent foundation grants
- manufacturer-sponsored patient assistance programs (for uninsured/underinsured patients)

When external financial support programs are unavailable, City of Hope maintains an internal prescription assistance program designed to provide financial support for eligible patients. This program functions as a safety net when other funding sources cannot be secured and reflects the institution's commitment to minimizing cost-related barriers to care.

Pharmacy teams rely on internal tracking systems to identify patients awaiting financial assistance opportunities. When new grant funding becomes available, eligible patients are contacted proactively to help secure financial support as soon as it becomes available.

Integration with Clinical Care Teams

The oncology pharmacy program at City of Hope operates in close collaboration with physicians, nurses, and care coordinators throughout the cancer care continuum. Pharmacists and pharmacy technicians communicate directly with clinical teams to resolve issues related to:

- insurance authorization
- medication dosing adjustments
- toxicity management
- therapy modifications

This level of integration allows pharmacy teams to intervene quickly when barriers arise. Pharmacists routinely assess drug interactions, assist with dose modifications when adverse events occur, and escalate clinical concerns directly

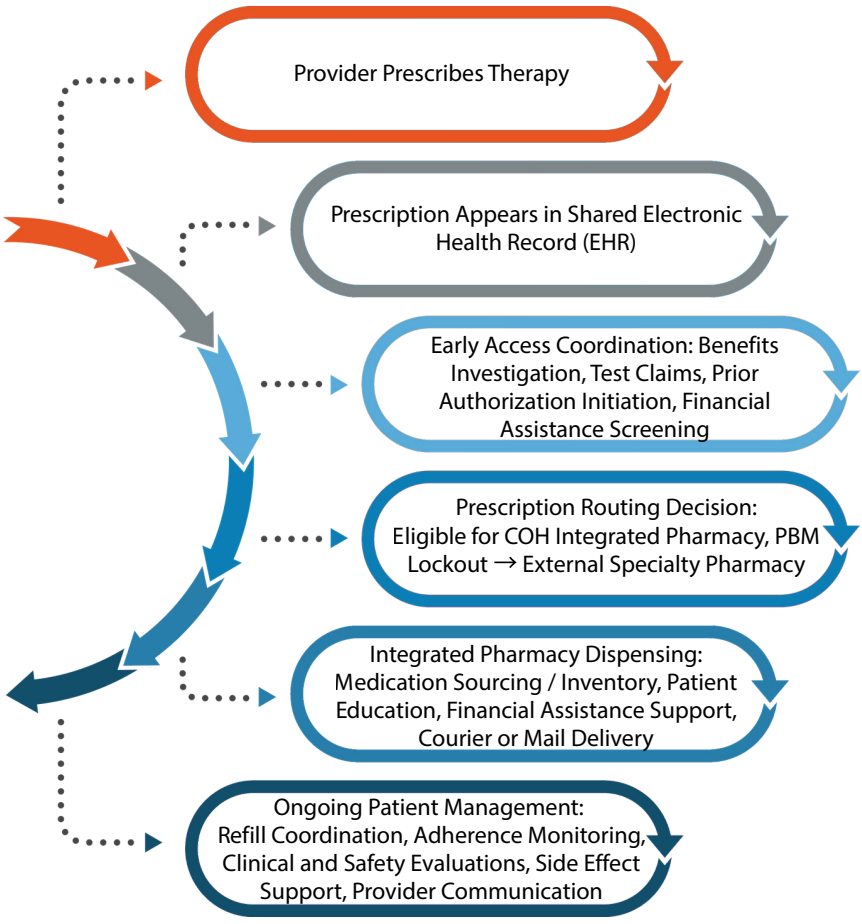


Figure 2. City of Hope Integrated Oncology Pharmacy Workflow.
The City of Hope oncology pharmacy model integrates prescription access coordination, dispensing, and patient support within the oncology care team

to treating providers when necessary. Pharmacists also provide ongoing patient education to reinforce adherence, set expectations for side effect management, and empower patients to remain engaged in their treatment. This promotes an optimal course of therapy and minimizes preventable therapy discontinuations.

Pharmacy teams also maintain regular contact with patients through structured follow-up calls and refill coordination programs. These interactions enable ongoing assessment of adherence, toxicity management, and treatment continuation.

Operational Performance and Dispensing Outcomes

To evaluate how pharmacy integration and distribution models influence dispensing performance, City of Hope analyzed prescription activity across three oral therapies used in later-line (third line and beyond) mCRC:

- fruquintinib (FRUZAQLA®)
- trifluridine/tipiracil (Lonsurf®)
- regorafenib (Stivarga®)

These therapies represent comparable treatment options in the mCRC care pathway but differ in their distribution structures. Fruquintinib is distributed through an OOLD network that includes oncology-focused integrated pharmacies, whereas regorafenib and trifluridine/tipiracil are distributed through an open specialty pharmacy networks that allows PBMs to route prescriptions outside the treating health system.

To better understand how these distribution pathways influence medication access and dispensing performance, several operational metrics were evaluated across the City of Hope network. These included capture rate, fill rate, and time to therapy initiation, which together represent sequential stages in the medication access process: prescription retention within the integrated pharmacy network, progression to a completed dispense, and ultimately the speed at which patients begin therapy.

Evaluating these metrics together provides insight into how pharmacy integration and distribution pathways influence operational efficiency and medication access for patients receiving oral oncology therapies.

While capture rate, fill rate, and time to therapy initiation reflect operational efficiency, evaluating therapy beyond the initial dispense provides additional context on patient engagement. Integrated pharmacy teams support patients through ongoing follow-up and refill coordination, enabling adherence monitoring, early identification of adverse effects, and timely intervention. To evaluate treatment continuation within this model, patient retention and refill

Metric	Fruquintinib	Trifluridine/Tipiracil	Regorafenib
Total Patients Evaluated	64	101	39
Patient Retention Rate (≥1 Refill)	67.2%	58.4%	33.3%
Average # of Fills (Retained Patients)	3.7	5.2	5.2
Capture Rate	77.4%	53.3%	49.4%
Fill Rate	81.1%	56.9%	67.4%
Time to Fill	4 days	3 days	9 days

Table 1. Operational and patient-level pharmacy performance metrics for oral therapies used in later-line metastatic colorectal cancer, based on dispensing activity within the City of Hope integrated pharmacy network. Total patients evaluated reflects the number of patients with documented dispensing outcomes across all sites. Patient retention rate is defined as the proportion of patients who continued therapy beyond the initial dispense. Metrics reflect internally captured prescription activity and may underestimate total treatment continuation for prescriptions dispensed outside the network.

activity were analyzed. Together, these measures reflect sustained engagement over time and the impact of coordinated pharmacy support on adherence and continuity of care.

Capture Rate

Capture rate measures the proportion of prescriptions written within the oncology practice that are successfully dispensed through the integrated pharmacy network. This metric reflects the ability of the health system's pharmacy infrastructure to retain prescriptions within the medically integrated pharmacy environment rather than having them routed to external dispensing pharmacies. As a result, capture rate provides insight into how distribution pathways and payer routing requirements may influence whether oncology pharmacy teams remain directly involved in the patient's medication access and management process.

Across City of Hope sites, fruquintinib demonstrated the highest capture rate at 77.4%, compared with 53.3% for trifluridine/tipiracil and 49.4% for regorafenib. These differences illustrate how distribution structures and PBM routing requirements influence the likelihood that prescriptions remain within the integrated oncology pharmacy network.

Higher capture rates allow integrated pharmacy teams to maintain direct oversight of therapy access, patient education, and ongoing medication management. When prescriptions remain within the integrated pharmacy environment, pharmacy teams can work closely with prescribing providers to coordinate benefits investigations, initiate prior authorization requests, and assist patients in navigating financial support resources.

Maintaining pharmacy involvement throughout the dispensing process also enables structured patient education, proactive follow-up, and monitoring for treatment-related adverse effects. By keeping prescriptions within the oncology practice's pharmacy network, care teams are better positioned to provide coordinated medication management and support continuity of care for patients receiving oral oncology therapies. Higher capture rates highlight the value of distribution models that enable medically integrated oncology pharmacies to remain connected to the patient, preserving continuity of care. This sustained connection provides the foundation for ongoing patient engagement and contributes to higher rates of treatment retention observed within the medically integrated pharmacy model.

Importantly, as this analysis reflects only prescriptions retained and dispensed within the City of Hope integrated pharmacy network, the outcomes observed represent patients receiving complex oral oncology therapies under a highly coordinated, medically integrated model of care. Despite the inherent challenges of managing later-line mCRC therapies, these patients demonstrated strong engagement and continuity, underscoring the effectiveness of this approach. These findings suggest that if payer-mandated routing and external dispensing restrictions were minimized, allowing more patients to remain within the integrated oncology pharmacy model, even greater gains in treatment continuity, patient engagement, and overall care coordination could be achieved.

Fill Rate

Fill rate reflects the percentage of prescriptions that ultimately result in a completed medication dispense after the prescription is received by the pharmacy. This metric provides insight into the effectiveness of the medication access process and reflects the ability of pharmacy teams to navigate insurance authorization requirements, financial assistance programs, and dispensing logistics to ensure that patients receive their prescribed therapy.

Within the City of Hope network, fruquintinib demonstrated the highest fill rate at 81.1%, compared with 56.9% for trifluridine/tipiracil and 67.4% for regorafenib. These differences illustrate how PBM routing pathways and medication access processes influence whether prescriptions successfully progress from the initial order to a completed dispense.

Higher fill rates reflect more streamlined access pathways when pharmacy teams can directly coordinate dispensing and financial assistance within an integrated system. In these settings, pharmacy teams can initiate benefits investigations, manage prior authorization requirements, and assist patients in identifying financial support resources early in the process. This coordinated approach can help reduce administrative barriers and improve the likelihood that eligible patients ultimately receive their prescribed therapy.

Distribution pathways play a central role in driving these differences. Fruquintinib's availability through an OOLD network enables oncology-integrated pharmacies within the treating health system to directly manage the dispensing process. When prescriptions are retained within the integrated pharmacy environment, pharmacy teams can coordinate prior authorization, financial assistance, and dispensing logistics concurrently with clinical care, reducing administrative fragmentation and minimizing barriers between prescription and completed dispense.

Because fill rate captures the transition from prescription to medication access, it serves as an important indicator

of how effectively pharmacy workflows and distribution pathways support therapy initiation and continuity of care for patients receiving oral oncology therapies. A prescription only has value if it becomes therapy and medically integrated pharmacies make that transition more reliable. This reliability in therapy initiation establishes a critical foundation for sustained treatment engagement within an integrated care model.

Time to Therapy Initiation (Time to Fill)

Time to fill represents the average number of days between prescription receipt and medication dispensing. This metric reflects how efficiently pharmacy teams can navigate the administrative and logistical steps required to move a prescription from the point of order to medication delivery for the patient. These steps often include benefits investigation, prior authorization submission, financial assistance coordination, medication sourcing, and patient onboarding.

Across City of Hope sites, the average time to fill was:

- 4 days for fruquintinib
- 3 days for trifluridine/tipiracil
- 9 days for regorafenib

These timelines reflect the overall efficiency of the integrated pharmacy workflow while also highlighting how distribution pathways and payer requirements can influence the speed of therapy initiation.

As described earlier, pharmacy teams begin benefits investigations and prior authorization processes immediately upon prescription receipt, allowing access-related steps to occur in parallel rather than sequentially. Dedicated teams simultaneously evaluate insurance coverage, initiate prior authorizations, assess financial assistance eligibility, and coordinate medication sourcing, enabling administrative requirements to be addressed early and reducing delays between prescription receipt and therapy initiation.

Operational coordination also plays an important role in maintaining efficient turnaround times. Inventory teams monitor medication availability and proactively source therapies when prescriptions are anticipated, while pharmacy staff coordinate directly with providers through the shared electronic health record to resolve clinical or administrative questions in real time. When medications are available locally, delivery options such as courier services can further reduce delays by allowing patients to receive therapy on the same or next day.

Distribution pathways may also influence time to therapy initiation. When therapies are accessible through integrated pharmacy networks, care teams are able to manage authorization, dispensing, and patient communication within the same care environment. This coordination can reduce handoffs between external pharmacies and providers and may help streamline the steps required for patients to begin treatment. Within this integrated model, patients are able to initiate therapy when clinically appropriate, with minimal to no delays when prescriptions are retained and filled internally.

Because time to fill reflects the speed at which patients can begin therapy after a prescription is written, it provides an important indicator of how pharmacy integration supports timely treatment initiation. Timely therapy is not incidental; it is the result of coordinated systems working in parallel, not in sequence.

Treatment Continuation and Patient Retention

In addition to dispensing performance metrics such as capture rate, fill rate, and time to therapy initiation, treatment continuation patterns were evaluated to better understand longer-term therapy engagement. Integrated pharmacy teams maintain ongoing patient engagement through structured refill coordination and follow-up programs. These efforts enable pharmacy staff to monitor adherence, identify adverse effects early, and collaborate with providers to address barriers that may lead to treatment interruptions. This proactive approach supports treatment continuity and facilitates timely clinical intervention.

Patient retention and refill activity were evaluated to characterize treatment continuation across therapies. Treatment continuation was assessed using patient retention (continuation beyond the initial dispense) and the average number of fills among retained patients as a proxy for duration of therapy.

Across all sites, 67.2% of patients receiving fruquintinib remained on therapy beyond the initial dispense, compared with 58.4% for trifluridine/tipiracil and 33.3% for regorafenib. Among patients who continued therapy, the average number of fills was 3.7 for fruquintinib and 5.2 for both trifluridine/tipiracil and regorafenib. Although fewer patients receiving regorafenib remained on therapy, those who did demonstrated sustained treatment continuation, with an average of more than five fills per patient.

Together, these findings highlight higher rates of continued therapy with fruquintinib and demonstrate that, within an integrated care model, patients who remain on treatment can sustain therapy over multiple cycles across all therapies.

Importantly, treatment continuation should be interpreted within the broader clinical and economic context. Across all therapies evaluated, patient out-of-pocket costs remained consistently low, with average copays generally below $25 irrespective of dispensing channel. These findings challenge the perception that oral oncolytics are inherently associated with high patient financial burden and suggest that, within a coordinated oncology pharmacy infrastructure, affordability is not a primary driver of treatment discontinuation.

Within this context, patient retention within the medically integrated pharmacy model emerges as a clinically meaningful and operationally differentiating factor. When prescriptions are retained within oncology-integrated pharmacies, care teams maintain continuous visibility into medication use, enabling proactive adherence management, longitudinal monitoring, and early intervention for toxicity or access-related barriers. This level of oversight extends beyond what is captured in retention rates alone and represents a key driver of sustained therapy in real-world practice.

The ability to retain patients within an integrated pharmacy network supports ongoing clinical engagement and continuity of care. In contrast, when prescriptions are dispensed externally, fragmentation of pharmacy services may reduce visibility and limit opportunities for timely intervention, potentially increasing the risk of unrecognized non-adherence or treatment interruption. Notably, City of Hope employs a highly coordinated care model in which multidisciplinary teams proactively maintain clinical oversight, reinforce patient engagement, and ensure continuity of care regardless of dispensing channel through structured follow-up, patient education, and close provider–pharmacy collaboration. However, as this analysis was limited to prescriptions filled within the City of Hope pharmacy network, dispensing activity occurring outside the system was not captured; therefore, treatment continuation may be underestimated despite continued clinical management of these patients.

Discussion

This evaluation highlights how pharmacy integration and distribution design influence access to oral oncology therapies across the full care continuum, from prescription routing and dispensing to therapy initiation and sustained treatment continuation.

A key finding is the higher capture rate observed with fruquintinib, which reflects the ability of medically integrated pharmacy teams to remain directly involved in patient care. Retaining prescriptions within the integrated pharmacy model enables continuous coordination between pharmacy and clinical teams, supporting more efficient access, improved communication, and sustained patient management over time.

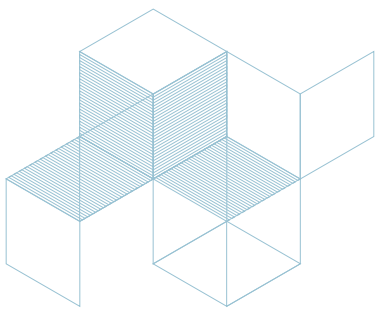
In contrast, prescriptions routed through PBM-directed specialty pharmacy networks introduce fragmentation into the care process. Additional handoffs, limited visibility into dispensing workflows, and reduced direct communication between pharmacy and care teams may delay issue resolution and limit opportunities for proactive patient support.

Differences in fill rate and time to therapy initiation further illustrate the impact of integration. Coordinated workflows within integrated pharmacy models allow administrative processes, such as prior authorization and financial assistance, to occur in parallel, reducing delays and supporting more timely therapy initiation.

Beyond therapy initiation, ongoing pharmacy engagement plays a critical role in sustaining treatment. Structured follow-up and refill coordination enable pharmacy teams to monitor adherence, manage toxicity, and intervene when barriers arise. Notably, consistently low patient out-of-pocket costs across therapies suggest that financial burden alone does not account for treatment disruption, underscoring the importance of coordinated pharmacy support in maintaining therapy.

These findings also highlight the role of distribution design. Fruquintinib's availability through an OOLD network enables alignment between prescribing providers and medically integrated pharmacies, supporting more coordinated and efficient care delivery.

Although this analysis reflects the experience of a single integrated health system, the implications extend more broadly. Distribution models do more than facilitate medication access, they determine whether care remains connected or becomes fragmented. Models that preserve integration with oncology care teams are better positioned to support timely access, sustained patient engagement, and continuity of care.



Conclusion

As oral oncology therapies continue to expand across multiple tumor types and treatment settings, ensuring timely, coordinated, and patient-centered access remains a critical component of high-quality cancer care delivery.

The City of Hope experience demonstrates that medically integrated oncology pharmacy programs can effectively address both the operational and clinical complexities of oral oncology therapy management. By enabling early access coordination, reducing administrative barriers, and maintaining close integration with oncology care teams, these models support more efficient therapy initiation and sustained patient engagement over time.

Findings from this analysis highlight the impact of distribution design on key access and delivery outcomes, including prescription capture, dispensing completion, and time to therapy initiation. Models that incorporate medically integrated pharmacies facilitate more coordinated care delivery and help preserve continuity beyond the initial dispense.

As treatment paradigms continue to evolve, distribution strategy should be recognized as a core component of oncology care delivery rather than a purely logistical function. Models that preserve integration with oncology care teams are better positioned to reduce fragmentation, improve access, and sustain patient engagement. In modern oncology, distribution design is inseparable from quality of care because access, coordination, and outcomes all depend on it.

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Disclosure

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NOTES:


NCODA