PQI IN ACTION
Positive Quality Intervention

NCODA

Inavolisib (Itovebi™) Patient Management

INTRODUCTION

NCODA developed the peer-reviewed Positive Quality Intervention (PQI) as an easy-to-use and relatable clinical guidance resource for healthcare providers. By consolidating quality standards, real-world practices, clinical trial results, package inserts and other guidance, PQIs equip the entire multidisciplinary care team with a comprehensive yet concise resource for managing patients receiving oral or IV oncolytics.

This PQI in Action builds on the Inavolisib (Itovebi™) Patient Management PQI and explores how medically integrated teams collaborate and utilize the information found in the PQI as part of their daily practice.

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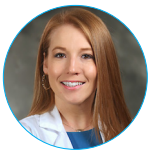

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Inavolisib for (HR)–Positive, (HER2)–Negative Breast Cancer

HORMONE receptor (HR)–positive, human epidermal growth factor receptor 2 (HER2)–negative breast cancer is the most common subtype of breast cancer and is frequently driven by dysregulation of key signaling pathways involved in cell proliferation and survival. Activating mutations in the phosphatidylinositol 3-kinase catalytic subunit alpha (PIK3CA) gene occur in approximately 35–40% of HR-positive breast cancers and are associated with resistance to endocrine therapy and poorer clinical outcomes in advanced disease.[1,2]

Current treatment approaches for HR-positive, HER2-negative locally advanced or metastatic breast cancer typically include endocrine therapy alone or in combination with targeted agents such as cyclin-dependent kinase 4 and 6 (CDK4/6) inhibitors. The addition of targeted therapies, including PI3K, AKT, or mTOR inhibitors, may be considered following disease progression; however, treatment resistance remains a major clinical challenge, and tolerability of existing PI3K inhibitors has limited their use in practice.[3] Current NCCN Clinical Practice Guidelines recommend biomarker-directed therapy and emphasize the importance of clinical trial participation for patients with advanced or metastatic disease.[4]

Despite these available therapies, many patients with PIK3CA-mutated disease experience disease progression on or shortly after endocrine-based regimens, highlighting a continued unmet need for more effective and better-tolerated targeted treatment options.[1,2]

Inavolisib (Itovebi™) is an oral, highly potent and selective inhibitor of the p110α isoform of PI3K that also promotes degradation of the mutated p110α protein.[1,5] By targeting a key oncogenic driver of endocrine resistance, inavolisib enhances inhibition of the PI3K pathway while potentially improving tolerability compared with earlier agents.[3,5] Inavolisib is FDA-approved in combination with palbociclib and fulvestrant for the treatment of adults with endocrine-resistant, PIK3CA-mutated, HR-positive, HER2-negative locally advanced or metastatic breast cancer following recurrence on or after completing adjuvant endocrine therapy.[6]

Approval was supported by the phase 3 INAVO120 trial, which evaluated inavolisib in combination with palbociclib and fulvestrant compared with placebo plus palbociclib and fulvestrant in patients with PIK3CA-mutated advanced breast cancer. Inavolisib significantly improved progression-free survival (15.0 vs 7.3 months; hazard ratio for disease progression or death, 0.43; P<0.001) and demonstrated a higher objective response rate (58.4% vs 25.0%).[1,2] Updated analyses also demonstrated a significant overall survival benefit, with median overall survival of 34.0 months in the inavolisib group compared with 27.0 months in the placebo group.[1]

The safety profile of inavolisib is consistent with inhibition of the PI3K pathway, with common adverse reactions in patients receiving inavolisib/fulvestrant/palbociclib including neutropenia, anemia, hyperglycemia, stomatitis, diarrhea, fatigue, and rash.[6] Notably, hyperglycemia is a key safety consideration and may be severe or life-threatening, requiring baseline assessment and ongoing monitoring of glucose levels, as well as prompt management with antihyperglycemic therapies when indicated.[6]

By selectively targeting PIK3CA-mutated disease and improving outcomes when combined with established therapies, inavolisib represents an important advancement in the treatment landscape for patients with HR-positive, HER2-negative advanced breast cancer, addressing a critical unmet need in endocrine-resistant disease.

Why the PQI Matters

FOR oncology teams managing patients on inavolisib, the PQI provides a practical roadmap for starting therapy, monitoring, managing adverse events, and helping patients stay on treatment. Rather than restating drug basics, the PQI turns complex information into clinic-ready action steps.

Katelyn Linker, DNP, AGNP-BC, described the PQI as a concise, user-friendly tool for busy practice. "It was very much to the point and really had everything we needed, from what do we do to start, to what do we do to monitor, to when would we need to stop," Linker said. She noted that while prescribing information includes the details, the PQI makes the most important information easier to find and apply when the patient is sitting in front of the care team.

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>
> — Katelyn Linker, DNP, AGNP-BC

Heather Moore, PharmD, BCOP, CPP, emphasized that this type of guidance is increasingly important as breast cancer care becomes more complex. With PI3K inhibitors, AKT inhibitors, CDK4/6 inhibitors, antibody-drug conjugates, and other targeted therapies, teams need clear strategies for baseline assessment, prophylaxis, monitoring, and toxicity management.

Dr. Moore said the PQI is helpful for confirming that "we have all of our baseline labs," that therapy is appropriately indicated, and that supportive care strategies, such as metformin or cetirizine when needed, are considered early. For Dr. Moore's team, proactive management has been especially important for reducing severe hyperglycemia, preventing unnecessary dose holds or reductions, and supporting adherence.

Rani Bansal, MD, noted that the PQI is especially useful for community oncologists who manage many tumor types and may only use certain breast cancer therapies occasionally. "This resource does a really good job of laying out what should you be looking at and things you need to monitor," Dr. Bansal said.

Dr. Bansal also highlighted medication review and drug interactions as key areas where quick-reference guidance can support safe use. At its best, the PQI creates a shared care process for the medically integrated team, helping practices identify appropriate patients, prepare for adverse events, intervene early, and keep patients safely on therapy.

Patient Selection: Identifying the Right Fit

AFTER showing how the PQI serves as a clinic-ready resource, the next step is applying it to the first key decision point: identifying which patients may be appropriate for inavolisib-based therapy.

The PQI emphasizes that patients should have HR-positive, HER2-negative, PIK-3CA-mutated advanced or metastatic breast cancer with disease recurrence on or after completion of adjuvant endocrine therapy.[1] Per NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®), this may include disease progression on adjuvant endocrine therapy or early relapse within 12 months of completing adjuvant endocrine therapy.[4] PIK3CA mutation status should be confirmed through appropriate testing.

Dr. Bansal shared she is currently using inavolisib, palbociclib, and fulvestrant for patients who match the trial population: newly diagnosed metastatic disease after being on endocrine therapy or within 12 months of stopping it. "I am sticking to the trial eligibility as of right now," she said.

Patient Selection: Identifying the Right Fit - continued

Linker noted that the team commonly uses Guardant for blood testing or Caris for tissue testing, depending on tissue availability.

At Cone Health, Praveena Iruku, MD, is using the regimen for endocrine-refractory or endocrine-resistant disease. "We are picking patients who have been on anti-estrogen therapy but have now progressed to metastatic disease, or they have had five years of anti-estrogen therapy and within one year they now have metastatic disease," she shared.

Across practices, timely testing is essential. Dr. Iruku's team tests at stage IV diagnosis using Guardant360, with results typically returning in about 7 to 10 days. Dr. Bansal also emphasized the importance of fast testing and often sends blood-based next-generation sequencing the same day as the visit, while using tissue-based testing when available.

> "Testing is the only way to find out if patients are eligible."
>
> — Rani Bansal, MD

The PQI prompts teams to assess baseline risk before therapy begins. Linker explained patients receive baseline CBC, CMP, fasting blood sugar, and hemoglobin A1C. Dr. Moore confirms baseline labs during education and may prescribe glucose monitoring supplies, metformin extended release or an SGLT2 inhibitor when appropriate, cetirizine, and dexamethasone mouth rinse. Dr. Bansal noted that age, diabetes risk, chronic kidney disease, and other comorbidities may influence how the team approaches treatment. In older or medically complex patients, the team may consider closer monitoring or whether a reduced starting dose is appropriate.

Together, these steps show how the PQI moves patient selection from a single eligibility question to a full readiness check: confirming the mutation, reviewing endocrine therapy history, assessing risk, preparing supportive care, and building a monitoring plan before treatment begins.

Multidisciplinary Team + Medically Integrated Pharmacy

FOR a regimen like inavolisib, the PQI is only as strong as the team putting it into action. Participants across both sites emphasized the same point: success depends on a multidisciplinary approach and a medically integrated pharmacy model that keeps communication tight, proactive, and patient-centered.

Dr. Moore said it plainly: "A multidisciplinary team is really essential for really complex regimens such as this."

WHY IT MATTERS:

- Monitoring must be proactive, structured, & ongoing
- Education must be thorough, practical, & reinforced throughout therapy
- There is little room for delayed communication
- Toxicities such as hyperglycemia & mucositis often require quick action

Linker noted that the entire team is involved "from starting the medication to monitoring the medication to continuing the medication." In practice, that means the physician or APP often introduces the regimen and discusses why it is being used, while the rest of the team helps operationalize safe treatment.

THE MEDICALLY INTEGRATED TEAM IN ACTION

Team members & roles in supporting inavolisib-based therapy

Medical Oncologist

- Identifies appropriate patients based on diagnosis, endocrine therapy history, & disease progression
- Ensures next-generation sequencing is ordered to confirm PIK3CA mutation status
- Confirms the patient fits the indication & is appropriate for treatment
- Leads treatment decisions, including regimen selection & dosing strategy

APP

- Reinforces the treatment rationale & helps connect the regimen to the patient's disease history & biomarker status
- Helps assess patient readiness, comorbidities, & overall tolerance
- Supports end-of-cycle follow-up, symptom management, & dose modification discussions
- Provides ongoing education & continuity between physician visits

Pharmacist

- Confirms the patient meets indication & has appropriate biomarker testing
- Reviews baseline labs, comorbidities, & drug-drug interactions
- Provides detailed oral oncolytic education, including adverse effects, glucose monitoring, supportive care, & when to report symptoms
- Supports toxicity management, dose strategy, & ongoing monitoring in collaboration with the care team

Nurse

- Reinforces patient education & medication instructions
- Triages patient calls related to side effects, symptoms, & medication questions
- Helps monitor for toxicities such as hyperglycemia, mucositis, fatigue, & diarrhea
- Coordinates care, follow-up, & communication across the team

Pharmacy Technician / Patient Advocate

- Reviews oral oncolytic prescriptions & begins access support early
- Assists with prior authorization, copay review, financial assistance, & grant availability
- Confirms biomarker results are available & supports documentation for approval
- Communicates potential access delays to the pharmacist & care team

Dietitian-Nutritionist

- Provides nutrition counseling for patients at risk for hyperglycemia
- Educates patients on glucose-conscious eating patterns & carbohydrate awareness
- Helps patients identify foods that may unexpectedly elevate blood sugar
- Supports individualized dietary strategies to help patients remain on therapy safely

Medically integrated pharmacy supports faster communication, proactive monitoring, and better continuity of care.

CPP Pharmacist Spotlight

CPP Pharmacist

- Confirms the patient meets indication & has appropriate biomarker testing
- Reviews baseline labs, comorbidities, & drug-drug interactions
- Orders labs or testing within scope when needed
- Provides formal oral oncolytic education & follow-up visits
- Prescribes supportive care medications & monitoring supplies when appropriate
- Monitors early toxicities, especially hyperglycemia, rash, mucositis, & diarrhea
- Adjusts supportive care plans in real time based on patient symptoms & lab results
- Collaborates with the oncologist, APP, nurse, & pharmacy technician to support adherence & treatment continuity

How the Clinical Pharmacist Practitioner helps bring the PQI to life

Heather Moore, PharmD, BCOP, CPP, & John Ingoglia, PharmD, BCOP, CPP, described a role that goes far beyond traditional dispensing.

What the CPP Pharmacist Does

The Clinical Pharmacist Practitioner plays a key role in turning the PQI into real-time patient care. In North Carolina, the CPP role includes prescriptive authority, which allows pharmacists to support education, monitoring, follow-up, and supportive care management in a highly integrated way.

Dr. Moore explained that having a CPP license allows her to bill for patient visits and prescribe supportive care medications needed for mitigation and management. For inavolisib, this can include metformin or other antihyperglycemic agents, cetirizine, glucose monitoring supplies, and dexamethasone mouth rinse.

"When I'm following up on a side effect, not only can I contact the patient and get a recommendation, but in real time I can then prescribe the supportive care that could be helpful," Dr. Moore said.

Dr. Ingoglia noted that the CPP license also allows pharmacists to practice with expanded clinical autonomy. If labs or tests are needed and have not already been ordered, the CPP pharmacist can order them within their scope of practice.

For a therapy like inavolisib, this level of integration is especially valuable. The CPP pharmacist can educate the patient, confirm baseline needs, monitor early toxicities, adjust antihyperglycemic therapy when needed, and quickly prescribe supportive care for issues such as rash or mucositis.

> "When I'm following up on a side effect, not only can I contact the patient and get a recommendation, but in real time I can then prescribe the supportive care."
>
> — Heather Moore, PharmD, BCOP, CPP

Dosing and Drug Interactions: Building Safety Into the Start

AFTER the team identifies an appropriate patient, the PQI moves into dosing, baseline optimization, and medication review. Inavolisib is dosed at 9 mg by mouth once daily, with or without food, until disease progression or unacceptable toxicity. It is prescribed in combination with palbociclib and fulvestrant.[1]

Before initiation, the PQI emphasizes the importance of evaluating fasting blood glucose and HbA1c, then optimizing glucose control prior to starting therapy. This step is especially important because INAVO120 included patients with an HbA1c less than 6%.[3]

In practice, teams described dosing as both protocol-driven and patient-specific. Linker shared that in her team's experience, many dose holds or reductions have been related to stomatitis or blood sugar issues.

For patients with fasting blood glucose consistently above 160 mg/dL, Linker said the team may pause therapy, adjust glycemic medications, and then restart at the same or lower dose. "Clinically, we often jump to a dose reduction, so that can get folks back on therapy consistently," she explained. Dr. Iruku said her team has been able to manage most side effects with support from Dr. Ingoglia and with dose modifications when needed.

Medication review is also critical because this is a triplet regimen. Dr. Moore emphasized that teams must think about both inavolisib and palbociclib. Palbociclib is a CYP3A4 substrate, so CYP3A4 inhibitors may require dose adjustment and closer monitoring for neutropenia. She added that for some patients on agents such as verapamil or diltiazem, starting palbociclib at a reduced dose may be helpful, then modifying based on tolerance and labs.

Table 1. Inavolisib Dose Reduction Levels for Adverse Reactions[1]

Dose Reduction	Dosage	Number/Strength Tablets
Starting Dose	9 mg Daily	1 x 9 mg Tablet
1st Reduction	6 mg Daily	2 x 3 mg Tablets
2nd Reduction	3 mg Daily	1 x 3 mg Tablets

For inavolisib specifically, Dr. Moore highlighted renal function as a key dosing consideration. Unlike many oncology medications where pharmacists often think about a creatinine clearance cutoff of 30 mL/min, inavolisib requires attention at a higher threshold. Patients with creatinine clearance between 30 and 60 mL/min require dose modification to 6 mg.[1] Patients with creatinine clearance below 30 mL/min requires a dose modification to 3 mg.[6]

Dr. Ingoglia described medication review as part of the pharmacist's initial assessment. When the prescription comes through, the pharmacy team reviews drug interactions using Epic and additional third-party resources. If concerns are identified, Dr. Ingoglia said the pharmacist communicates with the medical oncologist early and provides recommendations before the patient starts therapy.

Adverse Event Management

Hyperglycemia

Once patients are selected and dosing is confirmed, the PQI shifts to proactive adverse event management. For inavolisib-based therapy, participants emphasized that prevention, early monitoring, and rapid communication are essential, especially during the first few weeks of treatment.

Laura Brown, LPN, highlighted the importance of making sure patients understand how to manage the medication and when to report symptoms. "Managing adverse events from inavolisib includes proactive prophylaxis, intensive monitoring, and dose modifications," Brown shared. "Ensuring patients have a clear understanding of medication management and symptom monitoring aids in success on the medication." She noted that patients receiving inavolisib are seen in clinic every three weeks for lab work, but also have access to the nurse triage phone line if concerns arise between visits.

The PQI outlines obtaining hemoglobin A1C, fasting blood glucose, CMP, and CBC with differential at baseline. It also emphasizes ensuring patients have glucose monitoring supplies, including a blood glucose meter, test strips, and lancets. Hyperglycemia can occur early, with a median onset of seven days, so fasting glucose monitoring should begin immediately and continue closely throughout therapy.[1]

> "Prevention is the key."
> – John Ingoglia, PharmD, BCOP, CPP

Dr. Bansal's team watches patients closely during the first few weeks. Patients complete baseline labs, begin home glucose monitoring, and receive early check-ins from the nurse and Dr. Moore. "It really is a whole team approach," Dr. Bansal shared. During the first month or two, patients are seen frequently to assess glucose levels, diarrhea, rash, stomatitis, and overall tolerability.

Across practices, baseline diabetes status helps guide the plan. According to Dr. Iruku, patients with well-controlled diabetes may still be candidates for inavolisib, but uncontrolled diabetes requires optimization before or during treatment, often in collaboration with the patient's primary care physician or endocrinologist. She also noted that high blood sugars can be frightening for patients, making education and reassurance important.

Linker noted patients who are prediabetic and not already on metformin are often started on metformin before therapy. For patients with known type 2 diabetes, the team tries to optimize the current regimen, generally favoring metformin or SGLT2 inhibitors when appropriate. If metformin is not tolerated, some patients may be switched to an SGLT2 inhibitor.

Dr. Moore emphasized the importance of identifying risk factors up front, including BMI, fasting blood glucose, A1C, age, and history of gestational diabetes. Her approach is often to start metformin extended release 500 mg daily about one week before inavolisib, when appropriate, to allow time for tolerance and steady state before treatment begins. For higher-risk patients or those unable to tolerate metformin, an SGLT2 inhibitor may be considered.

Dr. Ingoglia described prevention as the key message during education. The pharmacy team confirms baseline A1C and fasting glucose before treatment starts, orders labs if needed, and provides clear instructions for home glucose monitoring. Patients are told to call if fasting glucose reaches 160 mg/dL, but Dr. Ingoglia encourages them to call earlier if they are concerned.

The goal is to avoid waiting until hyperglycemia becomes severe. By preparing patients, optimizing glucose control, monitoring early, and adjusting therapy quickly, the team can reduce treatment interruptions and help patients stay safely on therapy.

Mucositis

Mucositis is another adverse event where prevention matters. The PQI highlights the consideration of corticosteroid mouthwash, such as dexamethasone mouthwash, for prophylaxis and/or management. In INAVO120, 38% of patients used corticosteroid mouthwash.[1]

Across practices, participants described a proactive approach. Linker's team starts all patients on dexamethasone mouthwash to help prevent mucositis. She noted that continued education is important because patients may stop using the mouthwash if they have not developed symptoms. "We want patients to do that consistently," Linker said. "In my experience, it is a little easier to prevent than it is to treat."

Dr. Iruku also uses dexamethasone rinses preventatively. Dr. Moore typically prescribes dexamethasone mouthwash four times daily, while encouraging patients to aim for at least two to four times per day when full adherence is difficult. She also reviews oral hygiene strategies and may recommend saltwater and baking soda rinses.

Dr. Ingoglia explained his team has used lessons from prior experience with everolimus-based therapy and emphasizes a low threshold for patients to call if sores worsen, affect eating or drinking, or become more painful. If needed, the team may add other agents, such as magic mouthwash, or hold therapy depending on severity.

Rash & Diarrhea

Beyond hyperglycemia and mucositis, the PQI also supports proactive monitoring for rash and diarrhea. Across practices, participants emphasized early reporting, low thresholds for intervention, and clear patient education.

For rash, Linker starts cetirizine for prevention in most patients. Dr. Ingoglia noted that cetirizine may be used prophylactically, although it is not mandatory for every patient at Cone Health. The key is quick communication. "If the patient starts experiencing any sort of cutaneous reactions, they need to call us right away," Dr. Ingoglia explained. Depending on severity, the team may recommend topical steroids or other supportive care.

For diarrhea, Dr. Iruku said her team has generally managed mild cases with loperamide and has not needed dose modifications for grade 1 diarrhea in the patients treated so far. Dr. Ingoglia also explains to patients that loperamide is their go-to option once diarrhea begins, but not something they need to take prophylactically.

Patients are instructed to call if diarrhea worsens, especially if they experience four or more stools above baseline. At that point, the team becomes more concerned about dehydration, electrolyte abnormalities, and the need for earlier labs or additional intervention.

Patient Education: Make the Plan Usable at Home

PATIENT education is where the PQI becomes personal. Inavolisib-based therapy requires patients to learn more than a new medication. They are must navigate a triplet regimen, adhere to scheduled monitoring, incorporate supportive care into their routine, and recognize when symptoms warrant contacting the care team.

The PQI reinforces several key counseling points: take inavolisib once daily, with or without food, at approximately the same time each day; do not take two doses at once; document missed doses and report them to the care team; monitor closely for adverse effects; and use supportive care medications as directed.

Linker noted that education must focus on what will change for the patient at home. For many patients, the biggest adjustment is blood sugar monitoring. "The sugars are the big thing," Linker said, explaining that patients often need teaching on how to check glucose, when to check it, when to eat, how to take their medications, and how to build routines around dexamethasone mouthwash and supportive care.

Dr. Moore emphasized transparency. Triplet therapy can be overwhelming, especially for patients already processing a metastatic breast cancer diagnosis. She frames education around what to expect, what the team is doing to prevent toxicities, and what patients should do at home. "I think it can be really important to, with each side effect that you're going through, provide expectations," she said.

> "I think it can be really important to, with each side effect that you're going through, provide expectations."
>
> — Heather Moore, PharmD, BCOP, CPP

For hyperglycemia, that means giving patients clear parameters. Dr. Moore explains when glucose levels are acceptable, when the team may need to adjust medications, and when treatment may

need to be held. She also uses calendars to consolidate the regimen, including daily inavolisib, palbociclib's 21-days-on, seven-days-off schedule, fulvestrant injections, blood sugar checks, and prophylaxis.

Dr. Ingoglia also prioritizes interactive education. At Cone Health, patients receive the NCODA Patient Education Sheet for inavolisib in person, through Epic MyChart, or by mail, depending on preference. Dr. Ingoglia uses the sheet as a guide so patients can follow along during education and return to it later for dosing, side effect management, and supportive care strategies. "I try to take my education discussion with the patient and make it very interactive," he shared. "It's more a back and forth."

Dr. Ingoglia also highlighted the value of NCODA Patient Treatment Calendars for helping patients understand complex regimens in a more practical, visual way. The calendars can bring the treatment schedule, monitoring reminders, supportive care instructions, and patient education resources into one place. In addition to the education sheet and treatment calendar, practices may consider using the NCODA Treatment Support Kit to help patients prepare for therapy at home. The kit includes an educational booklet, treatment calendar, blood glucose monitor, thermometer, hydrocortisone cream, and loperamide, reinforcing several key components of the PQI in one patient-centered resource.

Dr. Iruku described the pharmacist-led oral chemotherapy education as "tremendously useful," noting that Dr. Ingoglia spends significant time reviewing side effects, when to report symptoms, and what patients should expect. Cassie Scott, CPhT-Adv, brought the process back to a simple but essential theme: communication. For access, coordination, and patient support, she said, "It's a phone call, it's multiple phone calls."

The takeaway is clear: patient education should be practical, repeated, and easy to act on. Patients need to understand the regimen, know what supplies and supportive medications they should have, recognize early symptoms, and feel confident calling the team before an issue becomes urgent.

Patient Assistance and Access: Start Early, Communicate Often

FOR oral oncolytics, access is part of patient care. Even when prior authorization is straightforward, out-of-pocket cost can create delays that affect when a patient can safely begin therapy.

Scott described the patient advocate role as moving quickly once the prescription is received. After the office visit and prescription submission, she begins the benefits investigation, determines whether prior authorization is needed, and works to submit the PA as soon as possible, often the same day or within 24 hours when all required testing and documentation are available.

Most approvals are not the challenge. Cost is. "We get the PA back and we're all excited and then it is unaffordable," Scott explained. "So it is what do we do next?" That next step depends on insurance type and financial need. For Medicare Part D patients with high copays, Scott looks for grants or foundation support through resources such as FundFinder, including PAN Foundation or HealthWell Foundation when available.

If grants are not open, the team may pursue manufacturer patient assistance. For commercially insured patients, the process often starts with manufacturer copay cards, followed by patient assistance if needed. Financial assistance options are available through Genentech for inavolisib.

Communication is essential because patients may not see the work happening behind the scenes. Scott contacts patients to explain insurance findings in plain language, review copay amounts, discuss affordability, and outline next steps. If assistance may delay the start of therapy, the patient advocate keeps the pharmacist and care team informed so everyone understands the timeline.

EARLY ACCESS WORK + **CLEAR** COMMUNICATION = **FEWER DELAYS AND A SMOOTHER START TO THERAPY**

Conclusion:

INAVOLISIB -based therapy requires more than knowing the indication. It requires a coordinated process that starts with patient selection and continues through testing, dosing, education, access support, and proactive adverse event management. As participants highlighted, the PQI helps translate that complexity into practical steps the care team can use in real time.

As practices adopt this regimen, success depends on building a coordinated, patient-centered care model. Identifying the right patients, preparing them before treatment begins, aligning communication across the multidisciplinary team, and proactively managing adverse events are all essential to helping patients start therapy with confidence, remain on treatment safely, and achieve the greatest potential benefit.

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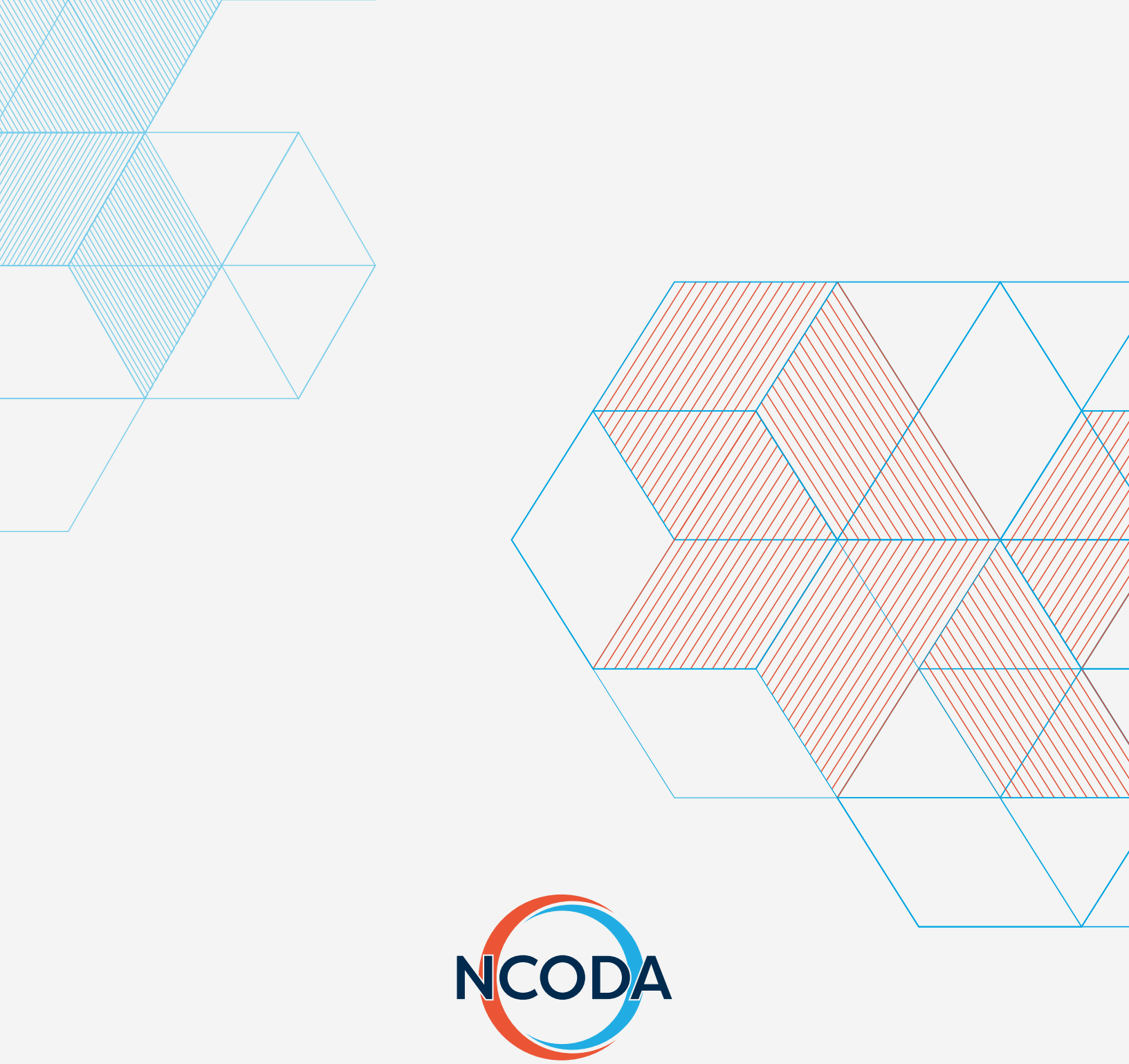
NCODA Treatment Support Kit



Practice panelist's comments reflect their experiences and opinions and should not be used as a substitute for medical judgment.