**Precision Medicine and Personalized Care**

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**SPEAKERS**

Narrator, Dr. Bill Evans, Kirk Wong

**Narrator** 00:00

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**Dr. Bill Evans** 00:21

well, welcome to the cancer ces podcast with your host, Dr. Bill Evans. Today, we're going to be talking with Kirk Wong, who's a pharmacist at the Juravinski Cancer Center. And I'm going to find out a little bit about what he does and how he helps patients who are receiving their medications on an outpatient basis. But before we start that conversation, I just like to remind our listeners that the cancer says podcast is brought to you by the cancer Assistance Program, based here in Hamilton, Ontario. And the cancer Assistance Program provides a variety of free services to cancer patients, including free rides, equipment, loans, nutritional and incontinence supplies, amongst a number of other supports for cancer patients. And these podcasts are meant to be a kind of support as well. And they're made possible by generous donations from individuals in Hamilton. And we hope that by learning more about cancer, and its causes, how it's currently treated, and the supports that are available in our community, that it will make the challenge of dealing with cancer just a little bit easier. So welcome to Kirk Wong, who, as I said, is a pharmacist in the oncology section of the Hamilton Health Sciences at the Juravinski hospital and Cancer Center. So pleasure having you here today, Kurt, an

**Kirk Wong** 01:39

honor to be invited on.

**Dr. Bill Evans** 01:40

Thank you so much. So I thought maybe we'd start with just a little bit about the training of a pharmacist, and then how you got to be an oncology pharmacist, because I don't think many people truly know the kind of training you go through to get to be a full fledged pharmacist. Yeah,

**Kirk Wong** 01:58

I think that's a good question. Things have changed a bit since the time I went through school. So when I went to school, you had to do minimum one to two years University and apply to the pharmacy program after completing those one or two years. And it was a bachelor's program. These days, it's what's called an entry level Doctorate of pharmacy, meaning that the degree will take five years to complete. There are practical rotations. And once that five years is complete, there is an option to conduct a residency. Now, there are not enough residency spots for all the pharmacists, so some will enter community practice right away, some will enter the industry. But that residency is not required. Although there are oncology based residences, it's not mandatory to become an oncologist, pharmacists, a lot of it is learning on the job.

**Dr. Bill Evans** 02:55

Right? It sounds like medical school, five years of training. So is that you go into the College of Pharmacy, if that's correct terminology, and then do five years within pharmacy. Wow, that's correct. So that's quite a change from what it was before. And I guess that just reflects the increasing number of drugs, the complexity of, of therapies that are available from logically and, and the amount of information you have to learn.

**Kirk Wong** 03:26

Yeah, I think that definitely for very many years, there was a shortage of pharmacists. And so when I went to school, there was only one school of pharmacy, which is University of Toronto, the University of Waterloo has their own pharmacy program now. And that sort of helped with what sort of labor demand in the profession

**Dr. Bill Evans** 03:47

sounds like so many areas in healthcare generally that there's a shortage. And we need to expand and so I was unaware that there was a pharmacy school in Kitchener Waterloo area. So that's, that's good to know. So you mentioned that you can do an oncology residency. And did you do that? Or did you kind of slide into it from being a pharmacist working in the hospital? Yeah,

**Kirk Wong** 04:15

I sort of slid into it, I suppose. Back in 2012, the Hamilton General was opening an outpatient pharmacy, and I was a community pharmacist at that time, and I thought this would be a great way to enter sort of a hybrid between the hospital and community practice where I see a bit of both patients being discharged out of the home, how do we transition to the community. At that point, the oncology world was starting to sort of pick up steam it started get a little more interesting with new drugs. And so I was asked to see if I could help out at the cancer center. And it was love at first sight and the

**Dr. Bill Evans** 04:55

rest was history. Right? What time was that when the You saw the changes in oncology. So when the molecular targeted drugs were coming in all these oral drugs, yeah,

**Kirk Wong** 05:06

I mean, there are already oral drugs. But you could tell from the clinical trials that there are more and more drugs coming down the pipeline, and they weren't going to get funded because of the evidence. And so that was around 2015, that I really notice a lot of changes in oncology space. And

**Dr. Bill Evans** 05:23

it's becoming almost a tsunami of drugs. And I think it's very hard to in fact, keep up it is exciting times, and I'm sure it's exciting as a, as a pharmacist to see the the new drugs that are coming in. It's exciting to oncologists, because they see the benefits of the patients. And they get to see some of that too, as they come back for refills on their medications. Yeah,

**Kirk Wong** 05:44

definitely. And I think one of the challenging facets of this is that as more and more drugs become take home therapies, there's going to be your community pharmacists who aren't as familiar with these medications, answering the needs of some of their patients who are receiving these. So we do try to serve a wide area, but we know that we cannot help 100% of our patients who pass through it, there are community pharmacies involved. And so we take pride on educating patients whenever we can and caregivers about these new oral therapies.

**Dr. Bill Evans** 06:22

I know that one point Cancer Care Ontario actually held a symposium about oral medication, in part because of what you described the increasing numbers of them, but the concern about the safety of them, given the fact that they could potentially be distributed by pharmacist who may not be as well versed in those drugs, and hence the the risks to patients have adverse effects or maybe, like so many prescriptions just get renewed at a certain point that if you renew some of these agents, and not on the schedule, that it was intended by the oncologist, it could be catastrophic. So this is part of your work also helping to educate pharmacists in in the community. There,

**Kirk Wong** 07:06

there is a little bit of that I have with some of my other colleagues made presentations to our peer group, but as well to the Hamilton District Pharmacists Association, not about all these unique therapies, but about general good to know. Information pieces, such as injection injections to boost white blood cell counts, for example, after chemo, and why they're being used and how to know when if there are no refills, you really need to call the doctor and make sure we don't leave this patient behind. Because of the risk of admission when the white counts drop too low after treatment is quite a dangerous thing.

**Dr. Bill Evans** 07:45

It's quite a different field of medicine, isn't it from, I don't know, cardiology, or neurology and so on. It's kind of this interesting, high risk, high gain potential. But it has does have to be carefully supervised. And hence, why it's so important to have pharmacists like yourself who are well versed in these new agents and can monitor with along with the oncologist that the patient's getting the right medication. One of the things that I think that pharmacists do much better than oncologists or other physicians is awareness of drug interactions. I know there always is the potential for different things and to interact in the pharmaceutical area. And patients don't just have one disease commonly right. So that must be challenging to keep up with or even have the knowledge. What do you do personally to kind of make sure that we're not getting unusual interaction between some new cancer drug and maybe their existing heart pills? Yeah,

**Kirk Wong** 08:57

I think that's a good question. There's certainly those common ones that any clinician you know, after seeing enough times is fully aware of, but at least at our practice, when we dispense medications, we always run through a computer database of all medications, we know the patient is taking, um, so that we can say for sure the likelihood of these problems occurring. So that's that's one factor. So

**Dr. Bill Evans** 09:27

there's a kind of search engine that will tell you if the two drugs will interact.

**Kirk Wong** 09:32

Yeah, there's clinical references that the hospital subscribes to, and so we will put all the medications in there as best as we can. Now in the pharmacy world, these days there is what we call polypharmacy, which is using multiple pharmacies, and you can avoid that patients have their own local pharmacy that they fill their regular medications at. And quite often, they will only visit the cancer center to Get these new specialized treatments now we are familiar with. So it's our job at the cancer center to really make sure that before we release it, that we've done our homework to ensure that there are no conflicts with whatever the patient is already taking, in addition to the physician, obviously, but it's best when both parties find themselves responsible and double

**Dr. Bill Evans** 10:23

check on the system. But how do you find out all the medications they're getting, including those that are being dispensed by a retail pharmacist in their own community? Yeah,

**Kirk Wong** 10:33

so that's called getting the best possible medication history, you have the patient telling you exactly what they're taking, you have maybe a caregiver who also helps out with the medications, corroborating that. And we can always call the local pharmacy that the patient uses, as well as sometimes we are able to look into the ministry's billing to ascertain what's been filled. Now what's been filled doesn't necessarily mean that taking that patient has actually taken that medication. So then we always have to circle back and just double check, is this what you're taking? And how are you taking it? Because that may also be different?

**Dr. Bill Evans** 11:14

Sounds like detective work? You're doing? A little bit of that?

**Kirk Wong** 11:19

Yeah, that's, that's for sure.

**Dr. Bill Evans** 11:22

No, you, your face sort of lit up, when you come in about moving from the general in the outpatient or the retail pharmacy, they were started down there to, to oncology what excited you about coming to an oncology setting?

**Kirk Wong** 11:36

I think it's a pace of change. And you're always at the forefront of all of these changes. It's funny, you know, I mentor students, and sometimes they come in and ask them, let me show you what you've learned in school so far. Now just point at the slide and say, Okay, well, that is no longer relevant, there's new data out. And this is what we do now for these patients. And I think it just, there's so much happening, and just is so exciting to be able to help patients.

**Dr. Bill Evans** 12:05

So it's the pace of change the new discoveries, the advances, it's really encouraging. I'd have to agree with you, because I'm a semi retired oncologist now, but it is exciting to see the progress that's being made against cancer and, and the results really are much more hopeful. And you're seeing it in the drugs that you're dispensing. And one of the downside of all the new medications that they're often very expensive. And if it's in the hospital, within the hospital budgets, picking it up, if it's an oral agent, depend depends on a number of factors, I guess. And I think that's another role where the pharmacists are really critical in helping the patient access some of these expensive medicines. I don't understand drug plans very well. But maybe you could give a high level kind of view of drug plans. And then we'd like to talk a bit about what happens when patients really can't afford one of these new but very expensive drugs. Yeah,

**Kirk Wong** 13:10

and you know, you're very right in saying that these medications are often very expensive. And just so the listeners have an idea, it's not uncommon for some of them to cost nine to $10,000 a month. And so when we think about how do we access these medications, that's really a rule for our drug access navigators. And so the hospital outpatient pharmacy is very much like a community pharmacy in the sense that if anyone wanted to come by and fill a prescription for a common antibiotic, or maybe a blood pressure pill, we could fill that, although we do cater to a very unique patient population. Now, what's also different is that our drug access navigators, our five registered pharmacy technicians, who know the sort of pharmacy world and drug plans in a bit of detail to help the doctors final what will be covered by calling those drug plans. Now, let's say it's someone of working age who might have private drug coverage do their work, we can find out what the coverage is, is it a percentage is a patient going to be paying out of pocket, let's say 20% of the drug costs, and that can be quite stressful. When you think of 20% of a $10,000 drug, that's still $2,000 a month out of pocket. Even if it's a patient with 100% plan, we would still find out if maybe, if there's a lifetime maximum, you know, are we going to exhaust this patient's coverage in a couple of months down the road, and how do we manage that? So there is a government drug plan called the Trillium Drug plan that we always help patients up High four. And whether or not it's needed is really a question of looking at all the factors for the patient has the income changed so much so that the drug costs are high percentage of family income is the 20%, for example, out of pocket costs, still making up a large portion of that family's income. That is a government run drug plan that is income tested. So the only requirement is that patients are up to date with our taxes. And we can certainly expedite applications. So there's always ways to get drugs covered.

**Dr. Bill Evans** 15:41

That's good to hear. I think a lot of patients would like to know that there's always ways, I guess, one of the factors we should make clearly, at least in Ontario, like if you're 65 years of age or older, or on social assistance, and it would be covered, I think one of the big problems is younger patients, and of course, there's more than a few younger individuals who get cancer and that's where it's really potentially a hardship if they don't have a really good drug plan through their work, or high copay or, or factors like that. So in some provinces in Canada, it's totally covered, if you have a diagnosis of cancer, basically, in the western provinces and Ontario in the maritime provinces tend to be different and have this requirement around age two is kind of unfortunate. But it certainly can put people in a difficult position of, of spending a large percentage of their income just to cover their drugs,

**Kirk Wong** 16:41

you're right. And even with the cost of these medications, even if there is a really good drug plan, or there is the Trillium Drug application, active, a lot of these medications do need a prior approval still, the insurer so again, that's where the drug access, Navigators will come in, they will assemble the documents required and make the physicians lives a little bit easier.

**Dr. Bill Evans** 17:06

But those prior approvals take some time. And I guess I must be a high anxiety time for the patient and, and their support. So when is it going to be available because the doctor has ordered it, I've got cancer and cancer is going to be progressing. And I don't get on this medication quickly. And so what is the kind of time to get an approval for some of these things?

**Kirk Wong** 17:26

You know, it varies sometimes to the Ministry of Health with with their approval process, it can be as soon as 24 hours. The program is called Sadie I don't know too much into I don't know too much about the mechanics. But I know that I have seen approvals come back within a day. The private drug world is a little bit different. But what I can say is this is that we very often can bridge patients, meaning that while we're waiting for these approvals to come through, we can minimize the delay by providing some compassionate drugs through the own pharmacy, and pretty much all the time, which is a quite a unique service. Most community pharmacies will not be in a position to provide that level of service. Oh, well,

**Dr. Bill Evans** 18:17

I know. Well, that's good to know, though, for cancer patients that there's a willingness to kind of bridge the medications, so that would reduce the anxiety I'm sure many of them would feel if they had to wait days to weeks to find out if they can actually get coverage for their for their particular drug. Like we're gonna take a short break now and hear a message from the cancer Assistance Program and we'll be right back with Kurt Huang talking about pharmacy issues in the oncology world.

**Narrator** 18:47

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**Dr. Bill Evans** 19:31

We're back with Curt long talking about the oncology pharmacy and we just had some really good information before the break that I think was probably very reassuring to people who may not have the financial means to access these new and very expensive drugs, the access to the Trillium program operated by the government Ontario, the fact that approvals may be necessary but the pharmacy at the Juravinski is prepared to provide some bridging drug while we're waiting for approval, and it sounded like the approvals often come quite quickly, particularly coming through the government. But we want to talk a bit about the sort of the interaction with the patient receiving the medications at the pharmacy in the Juravinski. Patients come from across the city where we know we've got a lot of people with different languages, different levels of health literacy. And so that presents a challenge to try and inform them adequately so that they take the medications safely. And we know these medications have risks associated when they're not chemotherapy, and maybe ask you to explain that a little bit further, but they do have side effects. And so people have to be very well informed about the potential harms. And so how does that all happen in a busy pharmacy, people from different cultures, languages, levels of health literacy, how do you how do you manage all that sounds very complicated.

**Kirk Wong** 21:07

Yeah, that's, that's a lot of topics there. But why don't we start with the first one, you know, all these newer drugs that, you know, some of your medical oncologist guests have alluded to? How are they different from traditional chemo? Right, so traditional chemo, whether it's given intravenous, or whether it's a pill you take by mouth, it would go after any cells that are rapidly dividing, and interrupt somewhere in the cell cycle, so that cells, such as cancer that are rapidly dividing, they preferentially take up these nutrients, which is essentially the drugs that we give. And those drugs essentially kill off cells, but there's a lot of collateral damage some time. And so, you know, we always think about patients who have lost hair, for example, during chemo. Now, that's one of the side effects of these drugs. Whereas these targeted agents, as their name suggests, is that they're targeting certain, for example, genetic changes and cancer cells. And so their side effect profile, although it's, it's not as widespread, it still exists. And we always tailor our teaching to those medications, and really drive home when the patients really need to call the doctor. And when some of the side effects can be managed on their own, if they're milder in nature. And I think a very good example of this is a lung cancer drug called osimertinib, that Dr. Jergens had talked about. It's in a class of drugs that target EGFR. And without going into too much jargon, sometimes patients taking this medication will experience an acne like rash. And so we give patients a cream up front, and we tell them, if you get a rash that looks like acne, don't go to the pharmacy locally and buy acne treatments, it's more of this drug causing it. This creamer giving you is what you should use. And if it's Mother Nature, use the rash. Use it to treat the rash. And if it resolves, then great. But if it becomes much more widespread, that's when you would call on your oncologist. Little things like that are really important, because patients need to know what to expect prior to taking these treatments. So that's the tailoring the teaching. But you also had another question about different walks of life and cultures and how we manage

**Dr. Bill Evans** 23:44

that. Sorry about that too many questions.

**Kirk Wong** 23:48

And no, I think that with with any situation, you just try to simplify your language a little bit and use visual aid props. The fine. The things I find most interesting in the pharmacy world is that when I teach patients actually have a prop in front of my hands. Now I have an actual medication. So I can actually point to it and point on a calendar for example, and say, for the first 21 days, and a point along the calendar, you're taking two tablets in the morning, and then I can motion to my mouth and when you eat. And then two tablets in the evening, I say when you eat again, and you can use a clock to guide them. And then you sort of have to test the knowledge again afterwards and make them repeat back but they're repeating back in their own language perhaps, or they're speaking through a translator. So it's really more of gauging understanding exercise. I think the how isn't so much of a problem using usually,

**Dr. Bill Evans** 24:49

but I'm hearing that you have to take the time. Yes, this is not a quick here's your bag of drugs kind of thing. This is patiently walking through, I love the idea of having it repeated back to show that they've actually heard and listened and processed the information. Because these are drugs that are sort of in a class by themselves, right? That they're, they're very valuable for treating cancer, but they're also potentially harmful. harms may be different from the chemotherapy drugs, there's still potential harms. So getting them to take the just by the shedule, that they're supposed to take, it's 21 days, not 12 days or whatever, they're all different. What about compliance, that knowing that the patients actually taken the drugs that they should have? How do we know that they've they truly followed the directions you've given them in the oncologist as prescribed?

**Kirk Wong** 25:47

Oh, that's a very good question, too. And part of the teaching is giving maybe diary for the patient, to keep track of taking it if there's that concern. It may be unintentional. So part of the teaching is, you know, what happens if a patient does miss a pill? What if the patient took the medication but had a bit of nausea and vomiting? You know, half an hour later, you know, does the patient take another dose? Not the patient missed the dose? Do they double up the next one. And those are all No. Don't do that. When don't you don't do it. But for example, if it if it's a nausea, and if it's something that seems like it's happening with each dose, then we can give anti nausea medications upfront. And we commonly do for those treatments that we know do have a high rate of nausea, we do tell patients to take pills to treat that upfront rather than waiting for it to become more serious. And

**Dr. Bill Evans** 26:57

I think one of the things we should probably say is that the the drugs that are available to control nausea today are so much better than in the past. I think that there's probably a lot of people who still have heard that, you know, chemotherapy made so and so their, their late uncle very sick, and it was a terrible experience. Those certain ideas linger in the community and, and the anti nausea ins that are available today are pretty remarkable. And that doesn't mean they're perfect, but they're pretty remarkable. And side effects can certainly be minimized and much better controlled in the past. So fear of that should not be a factor in people's consideration about whether to take therapy or not. Any issues about how drugs are handled in the home, like in terms of safety and special ways of storing them or what what there's or any advice to be given around? Those sorts of things. I particularly think about safety, if there's children in the home and how to make it make sure that the kids don't end up taking grandmas anti cancer drugs. Yeah,

**Kirk Wong** 28:10

I think I think that's a good point. First of all, any medication, you know, anti cancer or not, should really be kept in a safe place out of reach of children, first and foremost. Now, because these medications are still hazardous, despite the fact that it's technically not chemotherapy, we still have to treat them as hazardous medications. So if it's a caregiver helping, I normally suggest not having the pills with their bare hands. If they come in a blister foil, maybe you can just pop it overflow into a little medicine cup. Before handing it to your loved one. There is the matter of what happens if there's soiled linens. And maybe that isn't something that your listeners are thinking about right now. But anything We consume food and medicines will end up in the toilet bowl either in the urine or feces. And so we always inform patients to close the toilet lead and then flush a full flush twice for patients who are on active chemo but I still like to recommend at least a full flush for those who are on these targeted treatments. And then for laundry. If there are soiled linens, you should wash the soiled linens on their own with a long wash cycle. really shouldn't mix it in with everyone else's laundry. That's not it's not that

**Dr. Bill Evans** 29:45

makes sense to me. But one thing that you said that caught my attention is closing putting down the toilet seat when you flush. And the reason for that is you don't want splashes you don't want splashes and And during COVID, there was actually articles about a vortex that's actually created with when the water is going down the toilet that actually causes an aerosol aerosol that goes up so that you couldn't be hate to think of it inhaling chemotherapy or molecular target agents in very small amounts, probably not terribly important. But still, in all, it's just makes sense to not expose people who don't need to be exposed to these things. So the vortex beware of the vortex and in your toilet bowl and close, but the lid doubt. You did talk about the challenges of communicating in other languages because we have such a wide variety of people from all over the world and living in Hamilton. So how do you how did you manage the best communication? Particularly if you don't have the staffing who speak the language of the patient who's in front of you?

**Kirk Wong** 30:55

Yeah, it's certainly very tough. Sometimes, you really need to take the time. And as I mentioned earlier, visual aids is really important. So just giving the main important information that you want up front, so that at least the patient knows how to take the medications, I think, is the most important thing I'm worried about first. Miss doses are really important. And then there is the matter of is it taken with food or without foods, and what foods to specifically avoid. So one of the classical drug food interactions is actually grapefruit juice. And, you know, listeners are probably fully aware that if they're on a cholesterol medication, they're advised by the pharmacist never to have grapefruit juice. And it's not, you know, not to separate it, it's not to have it ever, because the effects of the grapefruit will persist in the body and affect how the body handles the medication. In the case of some of these new agents, if it's something such as let's say a leukemia medication, and the grapefruit juice is consumed, there is a risk of toxicity because it's going to cause some of these drugs to linger around in the body at much higher concentrations, and for much longer than had bad grades or just not been consumed. So really telling patients what to avoid and how to take the medication is upfront, the most important piece of education I give?

**Dr. Bill Evans** 32:41

Well, I've learned something there that I didn't know is that oncologist, so I'm sure there's a lot of people who didn't know about the impacts of grapefruit juice on some of these new cancer therapies.

**Kirk Wong** 32:52

And it's not just limited to grapefruit juice, you know, I mean, an arborist or Binus probably give a better explanation. But Seville oranges, which is used to make marmalade exerts the same effects as grapefruit, like we tell patients, no marmalade, no Seville oranges.

**Dr. Bill Evans** 33:12

So these are the subtleties of the orange or the new anything. Yes, for sure. And

**Kirk Wong** 33:17

then if I'm counting someone, you know, from Asia, that I would have to throw an pomellato into the mix and tell them you know, don't have a Palmela because that's like a grapefruit tidbit that you pick up. It's

**Dr. Bill Evans** 33:31

these are these are the important tidbits, in fact, to make sure that the therapies work optimally. Otherwise, you may be negating the benefits of the prescription you're getting. Now, you must also see patients who are on clinical trials who are on some of these agents too. So is any the processes difference when you're managing the patient on a clinical trial studying the effects of new targeted therapies? I'm

**Kirk Wong** 34:00

actually not involved at all with clinical trials. So I don't know what the workflow looks like. Although I imagine that in a clinical trial setting, it is very controlled and manner in terms of education. In terms of lab work, what I can give you a little color is on is something called Special Access Program drugs, which are those very often that are now off clinical trials in other parts of the world and have great evidence for but the Health Canada approval has not yet been submitted or it's you know, in the process of and so a lot of these drugs that have come off trial, and maybe the patients at the center were part of those trials too. We can still access to the drug access navigators. So I'm glad you brought that up. So the other interesting thing is that once in a while we also use drugs off label. So for for those as listeners who are wondering what that means is drugs that we use for other cancers other than the one that it went to market with. So we had Dr McWhirter talking about melanoma, and how does B RAF medications to block this certain genetic aberration. And we have used this to compassionate means to treat hairy cell leukemia and thyroid cancers that have this genetic mutation as well. And so this has been the most interesting journey, finding that, hey, as a pharmacist, there's actually the this molecularly based medicine that we're seeing now, which is, you know, exciting to me.

**Dr. Bill Evans** 35:48

And if the drug is going to be used off label, what does that mean for you in terms of, do you have to get special approvals? Or how does that work?

**Kirk Wong** 35:57

Yeah, definitely. Very often, the private insurers, and the government insurance will not cover drugs off label. So it's essentially on a compassionate basis only. And the drug access navigators usually tried to request supply from the manufacturer on a case by case basis. uncompassionate means

**Dr. Bill Evans** 36:23

and does that mean that they sometimes provided free? Or do they provided a reduced costs? Or how does that work? And

**Kirk Wong** 36:29

very often is provided free? Because you really, I guess, someone in the pharma industry can give a better explanation, but they can't be seen as promoting a drug for purposes that Canada Yes, so there's no charge, it's just paperwork trail that needs to be followed?

**Dr. Bill Evans** 36:50

Well, we've covered a lot of ground here. I was very surprised when we started the conversation about the extent of training that's required. For pharmacists today, and then the additional training in oncology as as a as a residency and so on sounding so much like the length of time it takes to train a doctor. So but I guess of necessity, the complexity of pharmacy is so increasing that it's really necessary. And it's fascinating to to learn about the various ways in which you're informing patients, I really liked your description of how you use the visuals to, to really help Instruct the patient and how to do things appropriately, safely. And clearly, a lot of effort goes into ensuring that patients get access to the drugs they need, even if financially it's going to be a burden to them. Are there any things we haven't touched on in the conversation thus far that you think our listeners would like to know about? Oncology pharmacy,

**Kirk Wong** 38:01

not so much oncology pharmacy, but just some good things to keep in mind that had your appointments to do you have a good really functional conversation with their oncologist is to find out, you know, ask the question, when should you call, you know, what should I look for, you know, what sort of symptoms can I manage on my own. And really, it's all about empowering the patient. Because at the end of the day, if you're on some of these newer drugs, and you're taking at home, you have to be your best advocate, and you have to be the one watching out for how things are changing, compared to before you started the medication.

**Dr. Bill Evans** 38:43

So that's good advice, maybe a good place to stop and have that have our listeners think on those things. I really think it's been very informative. I learned a number of things out of this today. So I want to thank you very much for your your time, Kirk. It's, it's been very instructive and very practical. And as we close out today's podcast, just like to remind our listeners that they can listen to previous podcasts that we've done. At the cancer Assistance Programs website, that's cancer assist one word.ca. There's over 40 podcasts there covering a wide variety of different tumor types and treatment interventions and supportive care services here in the Hamilton area. So again, I want to thank Kirk Wong for his expertise, and today and all the things we've educated our listeners about in the world of pharmacy and oncology. Thanks very much.

**Kirk Wong** 39:38

Thank you for inviting me on to this. It's been a real blast.

**Narrator** 39:45

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