Save the Dates 2017 Calendar of Events

Charlotte Stone Crabs Charity Night
May 27, 2017 | 6:05 pm
Charlotte Sports Park
2300 El Jobean Road Building B, Port Charlotte, FL, 33948
Foundation.FLCancer.com/StoneCrabs

50 Shades of Pink
October 7, 2017 | 6 – 11 pm
Grand Hyatt Tampa Bay
2900 Bayport Drive, Tampa, FL 33607
Foundation.FLCancer.com/Pink17

Wine Women & Shoes
November 4, 2017 | 5:30 – 9:30 pm
The Westin Lake Mary, Orlando North
2974 International Parkway, Lake Mary, FL 32746
Foundation.FLCancer.com/WWS17

Kendra Scott Gives Back
June 8, 2017 | 5 – 8 pm
Hyde Park Village, 1511 West Swann Avenue, Tampa, FL 33606
Foundation.FLCancer.com/KendraScott

2018 Giving Challenge
May 1 – 2, 2018 | Noon to Noon
Online
Foundation.FLCancer.com/Giving

For information or to donate, please call (941) 677.7181 or visit Foundation.FLCancer.com

Florida Cancer Specialists Foundation is a 501 (c) (3) non-profit organization.
DEPARTMENTS

6  FCS News
30  FCS Events
36  Get to Know Dr. Reeves
43  HR Happenings

SPOTLIGHTS

28  Office Spotlight: Lee County
34  Senior Management Team Spotlight: Jeff Rubin
38  Nurse Spotlight: Jennifer Baptiste
40  Doctor Spotlight: Dr. Jorge Ayub

FEATURES

8  Puppy Love
16  2016 Clinical Summit Review
20  Partnership with Sarah Cannon Research Institute creates legacy of healing
22  FCS embraces Oncology Care Model
26  FCS Annual Operations Meeting Builds Relationships and Leaders

Vice President of Practice Operations, Jeff Rubin, and Family
Message from
Brad Prechtl

Dear Colleagues,

As you know, there has never been a time of greater (or faster) change in community oncology than the present. Clinical advances are not only altering the way we treat cancer, they are also driving the way providers must organize their businesses to remain successful. “Transforming the Business of Oncology through Science and Technology” was the theme of the 2017 Cancer Center Business Summit, which I had the pleasure of attending in February.

The conference concentrated on the many challenges we are facing, as oncology practices across the U.S. transition to value-based care. Keynote speaker, Dr. Bill Frist, who served as 18th Majority Leader in the U.S. Senate from 2003–2007, provided his viewpoint of what to expect in health care initiatives from the new administration in Washington; his message can be boiled down to two words: “expect change.” Oncology providers are focused on the changes that will come from the anticipated replacement of the Affordable Care Act, from proposed reimbursement modifications, from the climbing administrative costs associated with patient navigation and care management… and the list goes on.

There is no doubt in my mind that over the next few years there will be significant adjustments that will impact the delivery and future of cancer care; however, as the conference came to a close, I was struck by how well we, at Florida Cancer Specialists, have weathered previous challenges. As a company, we are well prepared to maintain our growth and succeed, despite a vast number of changes in our health care system. We will continue to be successful, I believe, because of our shared values and the remarkable people who live those values every day and always put our patients first.

Thank you to each of you for being “All In Every Day.”

Brad Prechtl
CEO
Save the Date

2017 FCS Nursing & Pharmacy Conference
Date: Saturday September 16, 2017
Time: 8 AM - 4:45 PM

Registration & Continental Breakfast: 8 AM - 8:30 AM

Place: Tampa Airport Marriott
4200 George J. Bean Parkway
Tampa, Florida 33607

Designed exclusively for FCS RNs, LPNs and Pharm-Techs, this conference is a great opportunity to learn from expert speakers and network with colleagues within your FCS Family.

Conference details and registration information will be available in the next few months.

We hope to see you there!
**FCS Delivers Holiday Joy to Local Families Affected by Cancer**

In December, FCS teamed up with Candlelighters of Southwest Florida, a local affiliate of the American Childhood Cancer Organization, to spread holiday cheer to two families with children who are undergoing cancer treatment. Thank you to the FCS employees who donated and raised nearly $2,000 to purchase gifts for the families. FCS Chief Operating Officer Todd Schonherz, Chief Revenue Cycle Officer Sarah Cevallos, Cheryl McAlpine and Scott Meyer personally delivered the gifts to the families.

**FCS Hosts Patient Appreciation Dinner at Tampa Cancer Center**

More than 500 patients and their families attended the fourth annual Thanksgiving Patient Appreciation dinner on Nov. 18 at the FCS Tampa Cancer Center. FCS physicians and staff and Tampa Bay Buccaneers special teams players Robert Aguayo, Bryan Anger and Andrew DePaola served up a delicious Thanksgiving feast with all the trimmings. All guests received a Thanksgiving pie to take home and share with their families.

**Cancer Survivor, Foundation Donate Blanket Warmer to FCS**

On Dec. 9, Dave and Bobbi Norris, along with the Make a Difference Foundation, gave the gift of warmth, in the form of a blanket warmer, to patients undergoing chemotherapy at the Lakewood Ranch office of FCS. The blanket warmer was donated during a special presentation that was followed by a patient appreciation breakfast.

FCS CEO Brad Prechtl said, “This generous donation will truly improve the treatment and the lives of our patients. All of our physicians and staff deeply appreciate the work that Dave is doing to help bring comfort to our patients.”

The Lakewood Ranch FCS office, where Dave was a patient, is the first FCS clinic to receive a blanket warmer from the Norris family, who plan to raise money to buy warmers for more than 50 other FCS treatment centers across the state.

**Dr. Lucio Gordan’s Research Published by the American Society of Clinical Oncology**

FCS is pleased to announce that Dr. Lucio Gordan, who practices at the Gainesville Cancer Center of FCS, was published in the American Society of Clinical Oncology’s Journal of Oncology Practice. His manuscript, “Unintended Consequences in Cancer Care Delivery Created by the Medicare Part B Proposal: Is the Clinical Rationale for the Experiment Flawed?” examines the inadvertent repercussions of the Medicare Part B experiment on oncology treatment. Dr. Gordan is on the editorial board of the Journal of Clinical Oncology Clinical Cancer Informatics, has been an investigator for numerous clinical trials and serves on the executive board of FCS.

**FCS Delivers Holiday Joy to Local Families Affected by Cancer**

In December, FCS teamed up with Candlelighters of Southwest Florida, a local affiliate of the American Childhood Cancer Organization, to spread holiday cheer to two families with children who are undergoing cancer treatment. Thank you to the FCS employees who donated and raised nearly $2,000 to purchase gifts for the families. FCS Chief Operating Officer Todd Schonherz, Chief Revenue Cycle Officer Sarah Cevallos, Cheryl McAlpine and Scott Meyer personally delivered the gifts to the families.

**FCS Hosts Patient Appreciation Dinner at Tampa Cancer Center**

More than 500 patients and their families attended the fourth annual Thanksgiving Patient Appreciation dinner on Nov. 18 at the FCS Tampa Cancer Center. FCS physicians and staff and Tampa Bay Buccaneers special teams players Robert Aguayo, Bryan Anger and Andrew DePaola served up a delicious Thanksgiving feast with all the trimmings. All guests received a Thanksgiving pie to take home and share with their families.

**Cancer Survivor, Foundation Donate Blanket Warmer to FCS**

On Dec. 9, Dave and Bobbi Norris, along with the Make a Difference Foundation, gave the gift of warmth, in the form of a blanket warmer, to patients undergoing chemotherapy at the Lakewood Ranch office of FCS. The blanket warmer was donated during a special presentation that was followed by a patient appreciation breakfast.

FCS CEO Brad Prechtl said, “This generous donation will truly improve the treatment and the lives of our patients. All of our physicians and staff deeply appreciate the work that Dave is doing to help bring comfort to our patients.”

The Lakewood Ranch FCS office, where Dave was a patient, is the first FCS clinic to receive a blanket warmer from the Norris family, who plan to raise money to buy warmers for more than 50 other FCS treatment centers across the state.

**Dr. Lucio Gordan’s Research Published by the American Society of Clinical Oncology**

FCS is pleased to announce that Dr. Lucio Gordan, who practices at the Gainesville Cancer Center of FCS, was published in the American Society of Clinical Oncology’s Journal of Oncology Practice. His manuscript, “Unintended Consequences in Cancer Care Delivery Created by the Medicare Part B Proposal: Is the Clinical Rationale for the Experiment Flawed?” examines the inadvertent repercussions of the Medicare Part B experiment on oncology treatment. Dr. Gordan is on the editorial board of the Journal of Clinical Oncology Clinical Cancer Informatics, has been an investigator for numerous clinical trials and serves on the executive board of FCS.
FCS Hosts Patient Appreciation BBQ in Spring Hill
On Nov. 4, more than 400 patients and their families and nearly 40 staff members attended the Fall Fling Patient Appreciation Barbecue dinner at the Spring Hill office of FCS. Patients were greeted with goody bags containing books, sunglasses, lip balm and T-shirts. FCS physicians and staff served up a delicious dinner at the fun evening event, which also featured music, raffles, live entertainment and photo opportunities with Tampa Bay Buccaneers wide receiver Louis Murphy.

Dr. Michael Diaz and Dr. Lucio Gordan Named to the Board of Community Oncology Alliance
FCS congratulates Dr. Michael Diaz and Dr. Lucio Gordan on being elected to the board of Community Oncology Alliance (COA). Dr. Diaz, who practices at the FCS St. Petersburg–St. Anthony and St. Petersburg–Pasadena offices, was named vice president and secretary of COA. Dr. Lucio Gordan, who practices at the FCS Gainesville Cancer Center, was elected by the COA Board to serve a first-time term on the Board of Directors.

FCS Announces New Office Location in Ocala
In early December, FCS announced the opening of a new clinic in Ocala. Medical oncologists Shilpa Oberoi, Vipul Patel and Craig Reynolds (MDs) are currently seeing patients at the new location.

FCS CEO Brad Prechtl said, “We opened our first office in Ocala in 2014, and because of rapidly increasing patient demand, we felt this second location in Marion County was needed. It represents another example of our commitment to serving and supporting our patients in communities, both large and small, throughout Florida. This facility will bring a wide range of treatments and services all under one roof, optimizing convenience for our patients in the Ocala community.”
Puppy Love

Volunteer program welcomes pet therapy teams to Villages Cancer Center

BY KIM HARRIS THACKER

Legendary actress, singer and animal welfare activist Doris Day once said, “I have found that when you are deeply troubled, there are things you get from the silent devoted companionship of a dog that you can get from no other source.”
It’s no secret that dogs and humans are suited for companionship. Study after scientific study demonstrates the many benefits of human-dog interaction, one of which is an increase in oxytocin, a powerful human hormone.

Rebecca Johnson, head of the Research Center for Human/Animal Interaction at the University of Missouri College of Veterinary Medicine, said, “Oxytocin has some powerful effects for us as to the body’s ability to be in a state of readiness to heal, and also to grow new cells.”

Healing and growing new cells is crucial to cancer patients who receive treatments through FCS. But the science behind pet therapy isn’t necessarily the reason that Howard Horwitz brings his dog, Dice, to Villages Cancer Center, an FCS treatment facility located in The Villages of Florida.

“People are sitting in the lobby or in the waiting room, and they don’t really want to be there,” Horwitz says. “I can relieve some of their stress with my dog. It really seems to work.”

Horwitz first started his pet therapy organization, The Canine Therapy Teams of the Villages, in 2009. Over the years, the organization has grown from two teams (a “team” consists of a dog and its owner) to about 60. This means that whereas the organization was once limited in its outreach, members can now travel throughout Lake, Sumter and Marion counties to perform pet therapy in assisted living homes, hospices, rehabilitation centers, schools and, of course, cancer treatment centers.

“We have 12 dogs that go to Villages Cancer Center, from my own dog, Dice, who is an 11-year-old, 92-pound female Bouvier des Flandres, to a little 5-pound Shorkie (Shih Tzu-Yorkie mix) by the name of Bailey,” says Horwitz, who serves as a volunteer pet facilitator for the FCS Foundation.

“Bailey’s whole body isn’t as big as Dice’s face,” says Bailey’s owner, Ken Allaby. Because Bailey is such a tiny dog, he spends a lot of time on patients’ laps.

“His temperament is unbelievable,” Allaby says. “He’s a dog with a gift. Sweetest animal I’ve ever met.”

Not only is Bailey sweet, he’s also acutely aware of the health of the people around him — something Allaby realized when the dog was just 2 years old.

“I was in my kitchen with him, and he started barking for maybe the first or second time ever,” says Allaby. “He never barks. But he knew something was wrong. That’s when I fell and hit my head. My wife came in and found me, and we went to the hospital. They told me I have A-Fib (atrial fibrillation, or an irregular heartbeat). Bailey rescued me.”

And Bailey is busy “rescuing” the patients at Villages Cancer Center to this day.

Each of the dogs that visit the center must be pet-therapy registered and up-to-date on vaccinations. Registration is gained through the Alliance of Therapy Dogs, which is based in Cheyenne, Wyoming.

“The Alliance has been going on since ’98, and they’re up to around 14,000 members,” Horwitz says.

With so many therapy teams around the country to choose from, Horwitz felt it was a great honor when, in 2015, the Alliance named him and Dice “the No. 1 pet therapy team in the U.S.” Horwitz was also the recipient of the 2015 Teri Meadows Outstanding Member Award “for his exceptional commitment and dedication to the mission of the Alliance of Therapy Dogs.”

Other awards that Horwitz and Dice have received include the American Kennel Club Distinguished Therapy Dog designation (2014), the Outstanding Therapy Team Award from the Florida Paws for Autism Association (2014) and an Alliance of Therapy Dog ”1,100 Visits” certificate.

Horwitz is definitely a pet therapy pro, but he always welcomes newcomers to his organization.

“When someone wants to join Canine Therapy Teams, we put their dog through a basic test,” he says. “If the dog does well, we go on three visits with the team. Based on the results of those visits, we invite the team to join the Alliance Therapy of Dogs. That gives the dog and handler liability insurance. Then we try to pair teams with sites they can visit that are near their homes.”

Whether a team visits a school, an assisted living facility or the cancer center, it’s a positive experience for everyone involved.

“We’ve had many people come up to us after we’ve visited them and tell us how it made it easier for them to be there,” says Horwitz. “Anything we can do to make their time there better, we’ll do it.”

To learn more about the FCS Foundation volunteer program, visit Foundation.FLCancer.com or call (941) 677-7191.
NINLARO® (ixazomib) for multiple myeloma: an all-oral regimen for patients who’ve received at least 1 prior therapy*

The treatment of multiple myeloma has advanced rapidly over the past decade. With a variety of treatment options now available, it’s increasingly more important to consider the role of specific agents and how they fit within the treatment plan for your patients. Takeda Oncology spoke with Shachar Peles, MD, of Florida Cancer Specialists and Research Institute, to learn more about how he chooses the appropriate treatment for his patients.

Q. How has the treatment of multiple myeloma evolved over the past decade?
A. It’s undergoing a revolution. In just the last few years, we’ve had so many additional options and classes of agents. But you really need to think ahead in your treatment strategy. It has almost become more like a chess game, where you have to think a few moves ahead. You can’t just sort of pick a drug. You have to stop and think about how it will affect your choices down the line.

Q. What role does NINLARO play in your treatment approach?
A. I think NINLARO with lenalidomide and dexamethasone is an effective regimen. It goes back to our basics of combining a proteasome inhibitor with an immunomodulatory drug and a corticosteroid—and this is an entirely oral regimen that may be convenient for patients. The randomized data from the TOURMALINE-MM1† trial show improvement in PFS (median: 20.6 vs 14.7 months [95% CI, 17.0-NE and 95% CI, 12.9-17.6 for the NINLARO and placebo regimens, respectively]; HR=0.74 [95% CI, 0.587-0.939]; P=0.012) and rapid responses (median time to response was 11 months vs 1.9 months, respectively).

*INDICATION
NINLARO is indicated in combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received at least one prior therapy.

IMPORTANT SAFETY INFORMATION
WARNINGS AND PRECAUTIONS
• Thrombocytopenia has been reported with NINLARO. During treatment, monitor platelet counts at least monthly, and consider more frequent monitoring during the first three cycles. Manage thrombocytopenia with dose modifications and platelet transfusions as per standard medical guidelines. Adjust dosing as needed. Platelet nadirs occurred between Days 14-21 of each 28-day cycle and typically recovered to baseline by the start of the next cycle.
• Gastrointestinal Toxicities, including diarrhea, constipation, nausea and vomiting, were reported with NINLARO and may occasionally require the use of antidiarrheal and antiemetic medications, and supportive care. Diarrhea resulted in the discontinuation of one or more of the three drugs in 1%
The approval of the NINLARO regimen (NINLARO+lenalidomide+dexamethasone) was based on a statistically significant ~6 month improvement in median PFS vs the placebo regimen (placebo+lenalidomide+dexamethasone) (median: 20.6 vs 14.7 months [95% CI, 17.0-NE and 95% CI, 12.9-17.6, respectively]; HR=0.74 [95% CI, 0.587-0.939]; P=0.012).

The NINLARO regimen demonstrated rapid responses

Median time to initial response (months)

<table>
<thead>
<tr>
<th>NINLARO regimen</th>
<th>1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo+len+dex</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Nonhematologic ARs occurring in ≥5% of patients with a ≥5% difference between the NINLARO regimen (n=360) and the placebo regimen (n=360)

- All grades, grade 3 (respectively): upper respiratory (19%, <1% vs 14%, <1%), peripheral neuropathies† (28%, 2% vs 21%, 2%), diarrhea (42%, 6% vs 36%, 2%), constipation (34%, <1% vs 25%, <1%), nausea (26%, 2% vs 21%, 0%), vomiting (22%, 1% vs 11%, <1%), rash † (19%, 3% vs 11%, 1%), back pain (21%, <1% vs 16%, 3%), peripheral edema (25%, 2% vs 18%, 1%)

- No grade 4 nonhematologic ARs occurred in either regimen

Serious ARs

- Serious ARs reported in ≥2% of patients included thrombocytopenia (2%) and diarrhea (2%)

†TOURMALINE-MM1: a global, phase 3, randomized (1:1), double-blind, placebo-controlled study that evaluated the safety and efficacy of NINLARO (an oral proteasome inhibitor) vs placebo, both in combination with lenalidomide and dexamethasone, until disease progression or unacceptable toxicity in 722 patients with relapsed and/or refractory multiple myeloma who received 1-3 prior therapies.2

‡Represents a pooling of preferred terms.

ARs=adverse reactions; NE=not evaluable; PFS=progression-free survival.
A director of pharmacy’s perspective on NINLARO® (ixazomib) and oral oncolytics

“We are seeing an increased use of NINLARO in our pharmacy and we are gearing up for that.”

Ray Bailey, RPh

Oral oncolytics are gaining greater traction in clinical practice. This is partly due to patient preference for oral administration.3 Takeda Oncology spoke with Ray Bailey, RPh, who oversees the operations of Florida Cancer Specialists’ oncology specialty pharmacy, Rx To Go, to learn more about his experience with the proliferation of new orals, such as NINLARO.

WARNINGS AND PRECAUTIONS (continued)

• **Hepatotoxicity** has been reported with NINLARO. Drug-induced liver injury, hepatocellular injury, hepatic steatosis, hepatitis cholestatic and hepatotoxicity have each been reported in < 1% of patients treated with NINLARO. Events of liver impairment have been reported (6% in the NINLARO regimen and 5% in the placebo regimen). Monitor hepatic enzymes regularly during treatment and adjust dosing as needed.

• **Embryo-fetal Toxicity:** NINLARO can cause fetal harm. Women should be advised of the potential risk to a fetus, to avoid becoming pregnant, and to use contraception during treatment and for an additional 90 days after the final dose of NINLARO. Women using hormonal contraceptives should also use a barrier method of contraception.

**ADVERSE REACTIONS**

The most common adverse reactions (≥ 20%) in the NINLARO regimen and greater than the placebo regimen, respectively, were diarrhea (42%, 36%), constipation (34%, 25%), thrombocytopenia (78%, 54%; pooled from adverse events and laboratory data), peripheral neuropathy (28%, 21%), nausea (26%, 21%), peripheral edema (25%, 18%), vomiting (22%, 11%), and back pain (21%, 16%). Serious adverse reactions reported in ≥ 2% of patients included thrombocytopenia (2%) and diarrhea (2%).

Please see Important Safety Information on this page and Brief Summary for NINLARO (ixazomib) adjacent to this advertisement.
The NINLARO regimen represented a sustainable treatment for patients

Discontinuation rates of the full regimen due to ARs

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Discontinuation Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NINLARO regimen (n=360)</td>
<td>13%</td>
</tr>
<tr>
<td>Placebo+len+dex (n=360)</td>
<td>11%</td>
</tr>
</tbody>
</table>

Discontinuation rates were low and comparable with the NINLARO and placebo regimens.

Q. How has your pharmacy evolved with the proliferation of oral oncolytics?
A. In the beginning, I don’t think any of us really knew how big oral oncolytics were going to be. At first we were just filling medications, talking to patients about interactions, side effects, and administration, and kind of checking in every now and again. But that just doesn’t work for orals. As an oncology pharmacy, you have to get a lot more involved to manage patients. I found that the way orals were dispensed and how patients were taken care of varied widely in practices around the United States. But what motivates me is helping patients because there may be a great need for orals.

Q. How does the pharmacist interact and engage with patients?
A. When it comes to oral oncolytics, we’ve developed an adherence platform where we can manage our patients. It’s interesting because even though a patient refills their prescription on time, it doesn’t mean they’re taking it properly. As a pharmacist, we want to make sure we can help measure how well a patient is responding to therapy and to me, the best measure of a good outcome is persistency. So we’re trying to connect with our patients and help get them over that hump during the first couple of months and see how long they can remain on therapy, as long as they are tolerating it and responding to it.

SPECIAL POPULATIONS

• Hepatic Impairment: Reduce the NINLARO starting dose to 3 mg in patients with moderate or severe hepatic impairment.

• Renal Impairment: Reduce the NINLARO starting dose to 3 mg in patients with severe renal impairment or end-stage renal disease requiring dialysis. NINLARO is not dialyzable.

• Lactation: Advise nursing women not to breastfeed during treatment with NINLARO and for 90 days after the last dose.

DRUG INTERACTIONS: Avoid concomitant administration of NINLARO with strong CYP3A inducers.

1 INDICATION
NINLARO (ixazomib) is indicated in combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received at least one prior therapy.

5 WARNINGS AND PRECAUTIONS
5.1 Thrombocytopenia: Thrombocytopenia has been reported with NINLARO with platelet nadirs typically occurring between Days 14-21 of each 28-day cycle and recovery to baseline by the start of the next cycle. Three percent of patients in the NINLARO regimen and 1% of patients in the placebo regimen had a platelet count ≤ 10,000/mm³ during treatment. Less than 1% of patients in both regimens had a platelet count ≤ 5000/mm³ during treatment. Discontinuities due to thrombocytopenia were similar in both regimens (< 1% of patients in the NINLARO regimen and 2% of patients in the placebo regimen discontinued one or more of the three drugs). The rate of platelet transfusions was 6% in the NINLARO regimen and 5% in the placebo regimen. Monitor platelet counts at least monthly during treatment with NINLARO. Consider closer monitoring during the first three cycles. Manage thrombocytopenia with dose modifications and platelet transfusions as per standard medical guidelines.

5.2 Gastrointestinal Toxicities: Diarrhea, constipation, nausea, and vomiting, have been reported with NINLARO, occasionally requiring use of antidiarrheal and antiemetic medications, and supportive care. Diarrhea was reported in 42% of patients in the NINLARO regimen and 36% in the placebo regimen, constipation in 28% and 25%, nausea in 26% and 23%, respectively, and vomiting in 22% and 11%, respectively. Diarrhea resulted in discontinuation of one or more of the three drugs in 1% of patients in the NINLARO regimen and < 1% of patients in the placebo regimen. Adjust dosing for Grade 3 or 4 symptoms.

5.3 Peripheral Neuropathy: The majority of peripheral neuropathy adverse reactions were Grade 1 (16% in the NINLARO regimen and 14% in the placebo regimen) and Grade 2 (6% in the NINLARO regimen and 5% in the placebo regimen). Grade 3 adverse reactions of peripheral neuropathy were reported at 2% in both regimens; there were no Grade 4 or serious adverse reactions. The most commonly reported reaction was peripheral sensory neuropathy (19% and 14% in the NINLARO and placebo regimen, respectively). Peripheral motor neuropathy was not commonly reported in either regimen (< 1%). Peripheral neuropathy resulted in discontinuation of one or more of the three drugs in 1% of patients in both regimens. Patients should be monitored for symptoms of neuropathy. Patients experiencing new or worsening peripheral neuropathy may require dose modification.

5.4 Peripheral Edema: Peripheral edema was reported in 25% and 18% of patients in the NINLARO and placebo regimens, respectively. The majority of peripheral edema adverse reactions were Grade 1 (16% in the NINLARO regimen and 13% in the placebo regimen) and Grade 2 (7% in the NINLARO regimen and 4% in the placebo regimen). Grade 3 peripheral edema was reported in 2% and 1% of patients in the NINLARO and placebo regimens, respectively. There was no Grade 4 peripheral edema reported. There were no discontinuations reported due to peripheral edema. Evaluate for underlying causes and provide supportive care, as necessary. Adjust dosing of dexamethasone per its prescribing information or NINLARO for Grade 3 or 4 symptoms.

5.5 Cutaneous Reactions: Rash was reported in 19% of patients in the NINLARO regimen and 11% of patients in the placebo regimen. The majority of the rash adverse reactions were Grade 1 (10% in the NINLARO regimen and 7% in the placebo regimen) or Grade 2 (6% in the NINLARO regimen and 3% in the placebo regimen). Grade 3 rash was reported in 3% of patients in the NINLARO regimen and 1% of patients in the placebo regimen. There were no Grade 4 or serious adverse reactions of rash reported. The most common type of rash reported in both regimens included maculo-papular and macular rash. Rash resulted in discontinuation of one or more of the three drugs in < 1% of patients in both regimens. Manage rash with supportive care or with dose modification if Grade 2 or higher.

5.6 Hepatotoxicity: Drug-induced liver injury, hepatocellular injury, hepatic steatosis, hepatitis cholestatic and hepatotoxicity have each been reported in < 1% of patients treated with NINLARO. Events of liver impairment have been reported (6% in the NINLARO regimen and 5% in the placebo regimen). Monitor hepatic enzymes regularly and adjust dosing for Grade 3 or 4 symptoms.

5.7 Embryo-Fetal Toxicity: NINLARO can cause fetal harm when administered to a pregnant woman based on the mechanism of action and findings in animals. There are no adequate and well-controlled studies in pregnant women using NINLARO. Ixazomib caused embryo-fetal toxicity in pregnant rats and rabbits at doses resulting in exposures that were slightly higher than those observed in patients receiving the recommended dose.

Females of reproductive potential should be advised to avoid becoming pregnant while being treated with NINLARO. If NINLARO is used during pregnancy or if the patient becomes pregnant while taking NINLARO, the patient should be apprised of the potential hazard to the fetus. Advise females of reproductive potential that they must use effective contraception during treatment with NINLARO and for 90 days following the final dose. Women using hormonal contraceptives should also use a barrier method of contraception.

6 ADVERSE REACTIONS
The following adverse reactions are described in detail in other sections of the prescribing information:
• Thrombocytopenia [see Warnings and Precautions (5.1)]
• Gastrointestinal Toxicities [see Warnings and Precautions (5.2)]
• Peripheral Neuropathy [see Warnings and Precautions (5.3)]
• Peripheral Edema [see Warnings and Precautions (5.4)]
• Cutaneous Reactions [see Warnings and Precautions (5.5)]
• Hepatotoxicity [see Warnings and Precautions (5.6)]

6.1 CLINICAL TRIALS EXPERIENCE
Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

The safety population from the randomized, double-blind, placebo-controlled clinical study included 720 patients with relapsed and/or refractory multiple myeloma who received NINLARO in combination with lenalidomide and dexamethasone (NINLARO regimen; N=360) or placebo in combination with lenalidomide and dexamethasone (placebo regimen; N=360). The most frequently reported adverse reactions (≥ 20%) in the NINLARO regimen and greater than the placebo regimen were diarrhea, constipation, thrombocytopenia, peripheral neuropathy, nausea, peripheral edema, vomiting, and back pain. Serious adverse reactions reported in ≥ 2% of patients included thrombocytopenia (2%) and diarrhea (2%). For each adverse reaction, one or more of the three drugs was discontinued in < 1% of patients in the NINLARO regimen.

Table 4: Non-Hematologic Adverse Reactions Occurring in ≥ 5% of Patients with a ≥ 5% Difference Between the NINLARO Regimen and the Placebo Regimen (All Grades, Grade 3 and Grade 4)

<table>
<thead>
<tr>
<th>System Organ Class / Preferred Term</th>
<th>NINLARO + Lenalidomide and Dexamethasone N=360</th>
<th>Placebo + Lenalidomide and Dexamethasone N=360</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infections and infestations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper respiratory tract infection</td>
<td>69 (19)</td>
<td>0</td>
</tr>
<tr>
<td>Nervous system disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peripheral neuropathies*</td>
<td>100 (28)</td>
<td>0</td>
</tr>
<tr>
<td>Gastrointestinal disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>151 (42)</td>
<td>0</td>
</tr>
<tr>
<td>Constipation</td>
<td>122 (34)</td>
<td>0</td>
</tr>
<tr>
<td>Nausea</td>
<td>92 (26)</td>
<td>0</td>
</tr>
<tr>
<td>Vomiting</td>
<td>79 (22)</td>
<td>0</td>
</tr>
<tr>
<td>Skin and subcutaneous tissue disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash*</td>
<td>68 (19)</td>
<td>0</td>
</tr>
<tr>
<td>Musculoskeletal and connective tissue disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back pain</td>
<td>74 (21)</td>
<td>0</td>
</tr>
</tbody>
</table>

General disorders and administration site conditions
Edema peripheral | 91 (25) | 0 | 66 (18) | 4 (1) |

Note: Adverse reactions included as preferred terms are based on MedDRA version 16.0.
*Represents a pooling of preferred terms

(Continued on next page)
Brief Summary (cont’d)

Table 5: Thrombocytopenia and Neutropenia (pooled adverse event and laboratory data)

<table>
<thead>
<tr>
<th></th>
<th>NINLARO + Lenalidomide and Dexamethasone N=360</th>
<th>Placebo + Lenalidomide and Dexamethasone N=360</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Any Grade</td>
<td>Grade 3-4</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>281 (78)</td>
<td>93 (26)</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>240 (67)</td>
<td>93 (26)</td>
</tr>
</tbody>
</table>

Herpes Zoster
Herpes zoster was reported in 4% of patients in the NINLARO regimen and 2% of patients in the placebo regimen. Antiviral prophylaxis was allowed at the physician’s discretion. Patients treated in the NINLARO regimen who received antiviral prophylaxis had a lower incidence (< 1%) of herpes zoster infection compared to patients who did not receive prophylaxis (6%).

Eye Disorders
Eye disorders were reported with many different preferred terms but in aggregate, the frequency was 26% in patients in the NINLARO regimen and 16% of patients in the placebo regimen. The most common adverse reactions were blurred vision (6% in the NINLARO regimen and 3% in the placebo regimen), dry eye (5% in the NINLARO regimen and 1% in the placebo regimen), and conjunctivitis (6% in the NINLARO regimen and 1% in the placebo regimen). Grade 3 adverse reactions were reported in 2% of patients in the NINLARO regimen and 1% in the placebo regimen.

The following serious adverse reactions have each been reported at a frequency of < 1%: acute febrile neutrophilic dermatosis (Sweet’s syndrome), Stevens-Johnson syndrome, transverse myelitis, posterior reversible encephalopathy syndrome, tumor lysis syndrome, and thrombotic thrombocytopenic purpura.

7 DRUG INTERACTIONS
7.1 Strong CYP3A Inducers: Avoid concomitant administration of NINLARO with strong CYP3A inducers (such as rifampin, phenytoin, carbamazepine, and St. John’s Wort).

8 USE IN SPECIFIC POPULATIONS
8.1 Pregnancy:
Risk Summary: Based on its mechanism of action and data from animal reproduction studies, NINLARO can cause fetal harm when administered to a pregnant woman. There are no human data available regarding the potential effect of NINLARO on pregnancy or development of the embryo or fetus. Ixazomib caused embryofetal toxicity in pregnant rats and rabbits at doses resulting in exposures that were slightly higher than those observed in patients receiving the recommended dose. Advise women of the potential risk to a fetus and to avoid becoming pregnant while being treated with NINLARO. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively. Animal Data: In an embryofetal development study in pregnant rabbits there were increases in fetal skeletal variations/abnormalities (caudal vertebrae, number of lumbar vertebrae, and full supernumerary ribs) at doses that were also maternally toxic (≥ 0.3 mg/kg). Exposures in the rabbit at 0.3 mg/kg were 1.9 times the clinical time averaged exposures at the recommended dose of 4 mg. In a rat dose range-findinglembryo-fetal development study, at doses that were maternally toxic, there were decreases in fetal weights, a trend towards decreased fetal viability, and increased post-implantation losses at 0.6 mg/kg. Exposures in rats at the dose of 0.6 mg/kg was 2.5 times the clinical time averaged exposures at the recommended dose of 4 mg.

8.2 Lactation: No data are available regarding the presence of NINLARO or its metabolites in human milk, the effects of the drug on the breast fed infant, or the effects of the drug on milk production. Because the potential for serious adverse reactions from NINLARO in breastfed infants is unknown, advise nursing women not to breastfeed during treatment with NINLARO and for 90 days following the last dose.

8.3 Females and Males of Reproductive Potential: Contraception - Male and female patients of childbearing potential must use effective contraceptive measures during and for 90 days following treatment with NINLARO and for 90 days after the last dose.

8.4 Pediatric Use: Safety and effectiveness have not been established in pediatric patients.

8.5 Geriatric Use: Of the total number of subjects in clinical studies of NINLARO, 55% were 65 and over, while 17% were 75 and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

8.6 Hepatic Impairment: In patients with moderate or severe hepatic impairment, the mean AUC increased by 25% when compared to patients with normal hepatic function. Reduce the starting dose of NINLARO in patients with moderate or severe hepatic impairment.

8.7 Renal Impairment: In patients with severe renal impairment or ESRD requiring dialysis, the mean AUC increased by 39% when compared to patients with normal renal function. Reduce the starting dose of NINLARO in patients with severe renal impairment or ESRD requiring dialysis. NINLARO is not dialyzable and therefore can be administered without regard to the timing of dialysis.

10 OVERDOSAGE: There is no known specific antidote for NINLARO overdose. In the event of an overdose, monitor the patient for adverse reactions and provide appropriate supportive care.

17 PATIENT COUNSELING INFORMATION
Advise the patient to read the FDA-approved patient labeling (Patient Information).

Dosing Instructions
• Instruct patients to take NINLARO exactly as prescribed.
• Advise patients to take NINLARO once a week on the same day and at approximately the same time for the first three weeks of a four week cycle.
• Advise patients to take NINLARO at least one hour before or at least two hours after food.
• Advise patients that NINLARO and dexamethasone should not be taken at the same time, because dexamethasone should be taken with food and NINLARO should not be taken with food.
• Advise patients to swallow the capsule whole with water. The capsule should not be crushed, chewed or opened.
• Advise patients that direct contact with the capsule contents should be avoided. In case of capsule breakage, avoid direct contact of capsule contents with the skin or eyes. If contact occurs with the skin, wash thoroughly with soap and water. If contact occurs with the eyes, flush thoroughly with water.
• If a patient misses a dose, advise them to take the missed dose as long as the next scheduled dose is ≥ 72 hours away. Advise patients not to take a missed dose if it is within 72 hours of their next scheduled dose.
• If a patient vomits after taking a dose, advise them not to repeat the dose but resume dosing at the time of the next scheduled dose.
• Advise patients to store capsules in original packaging, and not to remove the capsule from the packaging until just prior to taking NINLARO.

Thrombocytopenia: Advise patients that they may experience low platelet counts (thrombocytopenia). Signs of thrombocytopenia may include bleeding and easy bruising.

Gastrointestinal Toxicities: Advise patients they may experience diarrhea, constipation, nausea and vomiting and to contact their physician if these adverse reactions persist.

Peripheral Neuropathy: Advise patients to contact their physicians if they experience new or worsening symptoms of peripheral neuropathy such as tingling, numbness, pain, a burning feeling in the feet or hands, or weakness in the arms or legs.

Peripheral Edema: Advise patients to contact their physicians if they experience unusual swelling of their extremities or weight gain due to swelling.

Cutaneous Reactions: Advise patients to contact their physicians if they experience new or worsening rash.

Hepatotoxicity: Advise patients to contact their physicians if they experience jaundice or right upper quadrant abdominal pain.

Other Adverse Reactions: Advise patients to contact their physicians if they experience signs and symptoms of acute febrile neutrophilic dermatosis (Sweet's syndrome), Stevens-Johnson syndrome, transverse myelitis, posterior reversible encephalopathy syndrome, tumor lysis syndrome, and thrombotic thrombocytopenic purpura

Pregnancy: Advise women of the potential risk to a fetus and to avoid becoming pregnant while being treated with NINLARO and for 90 days following the final dose. Advise women using hormonal contraceptives to also use a barrier method of contraception. Advise patients to contact their physicians immediately if they or their female partner become pregnant during treatment or within 90 days of the final dose.

Concomitant Medications: Advise patients to speak with their physicians about any other medication they are currently taking and before starting any new medications.

Please see full Prescribing Information for NINLARO at NINLARO-hcp.com.

NINLARO is a registered trademark of Millennium Pharmaceuticals, Inc. Millennium Pharmaceuticals, Inc. is a wholly owned subsidiary of Takeda Pharmaceutical Company Limited.

©2016 Millennium Pharmaceuticals, Inc.
NOV 2016
USO/IXA/15/0123(3)
The FCS Clinical Summit is an annual event where most FCS physicians and senior managers attend to hear about important company updates, learn about new advances in oncology and hematology as well as network with peers from across the state. Through the coordination and planning of Marketing Coordinator Lynn Clemens and Chief Marketing & Sales Officer Shelly Glenn, the October 2016 summit had the largest attendance from Florida Cancer Specialists’ physicians and clinicians in history.

The Clinical Summit, Research to Practice, under the direction of Dr. Neil Love, provided a comprehensive full day Continuing Medical Educational program with experts from all over the country presenting key advances in hematology and oncology.

In addition, an FCS company update was provided to the Florida Cancer Specialists’ physicians by president and founder Dr. Bill Harwin, CEO Brad Prechtl, COO Todd Schonherz and Chief Revenue Cycle Officer Sarah Cevallos.

Also, Dr. Michael Diaz received the 2017 FCS Humanitarian Feature.
Award and Dr. Mary Li was recognized as the runner-up to this annual award.

For Dr. Manish Patel, the annual FCS Clinical Summit is a chance to share exciting advances in cancer treatment as well as to learn from other cancer researchers worldwide. As Director of Drug Development for the FCS Phase 1 Clinical Trials Program in Sarasota, Patel's patient roster is 100 percent enrolled in clinical trials, so he's constantly immersed in the ever-changing complexities of cancer treatments.

He appreciates the annual Summit because it gives him the chance to learn what's available to his patients through FCS clinics and, via the Sarah Cannon Research Institute (SCRI), to learn what is going on at the international level.

As a partner with FCS in clinical trials, Sarah Cannon Research Institute prides itself on being at the forefront of early-phase clinical trials. SCRI's recognized physicians are at the forefront of shaping new standards of cancer care based upon the latest research and have held a leadership role in the development of nearly 80 percent of the cancer drugs approved in the last three years—and that includes the FCS physicians and researchers who work hand-in-hand with SCRI.

The summit was held at the J.W. Marriott in Orlando on Oct. 29-30, 2016. Day one of the program highlighted advances found worldwide in cancer research – which Patel characterized as potentially practice-changing lessons.

Dr. Bill Harwin worked with Dr. Neil Love from Research to Practice to finalize the content for the Continuing Medical Education (CME) program on Saturday (Day 1), while Katie Goodman, FCS Director of Clinical Research, organized the day-two summit agenda. Her aim was to hold a research conference that would give FCS MDs, ARNPs and PAs an opportunity to share their work with peers and SCRI partners and serve as a forum for operational updates.

To that end, she arranged a day-two agenda full of FCS-specific trials and advances presented to all FCS physicians and senior clinical staff. This was the time for researchers like Patel to shine light on what they've learned and to pass along valuable lessons in the treatment of various cancers through early-stage trials.
The agenda covered early-trial advances in treatments for lung cancer, provided by Melissa Johnson, MD, Associate Director, Lung Cancer Research, Sarah Cannon; blood cancer, with Ian W. Flinn, MD, PhD, Director, Blood Cancer Research Program, Principal Investigator, Sarah Cannon; and a Phase 1 program update from Manish R. Patel, MD, FCS and Anita Kunwar, MPH, Senior Manager, Drug Development Unit.

Patel found interesting how immunotherapy and different manipulations of it to treat cancer have become a rapidly developing and “very hot” field over the last several years.

For Patel and other FCS physicians and physician researchers, the summit presented interesting data pertaining to immunotherapy in general, and the combined use of different types of immunotherapies. To Patel, this looks exciting.

The emerging approach involves using multiple immunotherapy targets in combination – versus in isolation, which is the “traditional” use of the still relatively new use of immunotherapy for cancer treatment.

"Now we are at the point where different combinations of immunotherapy will be the future, likely combining different immunotherapy drugs to treat the patient’s cancer," he explained. "Preliminary research such as CAR T-cell therapy in hematologic malignancies – including types of blood cancer and available treatment options – appears promising."

In the same way, advancements in other cancers show early promise.

Among cancer researchers, there’s an interest in a type of lung cancer therapy for a less-common mutation (T-cubaton 790, a resistant mutation). Certain drugs work very well in combatting this type of cancer, Patel explained. The summit presented interesting data about what drugs to use and when to give them for maximum efficacy — a very exciting advancement for FCS physicians.

"With every year of newer data," Patel explained, “we’re now talking more and more about immunotherapy. These drugs are relatively less toxic and have better efficacy. Year by year, this gets more exciting because of new technology that researchers like us are uncovering.”

In addition, physicians and senior clinical staff learned about Personalized Medicine Strategies in a presentation by Holli Hutcheson Dilks, PhD, Director, Personalized Medicine Operations, Sarah Cannon; and Judy Wang, MD, Sarasota Associate Director of Drug Development, FCS.

The morning rounded out with a presentation on Key Trial Strategies from David Spigel, MD, Chief Scientific Officer, Director, Lung Cancer Research Program, Sarah Cannon and an Operational Update: 2017 Goals presented by Katie Goodman, RN, Director of Clinical Research, FCS; Anita Kunwar, MPH, Senior Manager, Drug Development Unit; Jennifer Cole, RN, Vice President of Operations, Sarah Cannon; and Fran Palmieri, RN, Director Oncology Strategic Sites, Sarah Cannon.

Goodman’s aim when she created the summit agenda was to harness the synergy between FCS and SCRI. Talking about successes achieved and goals for year ahead is the main goal of each annual Clinical Summit, and Goodman and team clearly achieved that purpose.

“This is the one time to bring everyone together and inform them about what we are doing,” Goodman said. “Since the (2016) meeting, enrollment has increased by 10 percent in ongoing trials. We saw the same thing the previous year, so we know the meeting is valuable. It’s an important meeting for doctors to learn about what’s available for their patients.”

FCS is all over the state, and this is the only time that everyone comes together under one roof. There’s a lot to be said about seeing someone face to face, and Goodman clearly understands that and capitalizes on making such interaction happen.
OUR LOCATIONS

Altamonte Springs • Apopka • Atlantis • Bonita Springs • Bradenton (3) • Brandon • Brooksville (2) • Cape Coral (2) • Clearwater (3) • Clermont • Crystal River • Davenport • Daytona Beach • Deland • Englewood • Fort Myers (2) • Gainesville • Hudson (2) • Inverness • Lady Lake (3) • Lake Mary • Lake Wales • Lakewood Ranch • Land O’ Lakes • Largo (3) • Lecanto • Leesburg (2) • Naples (4) • New Port Richey (2)

New Smyrna Beach • North Port • Ocala (2) • Orange City • Orlando (2) • Ormond Beach (2) • Oviedo • Palm Beach Gardens • Palm Coast (2) • Poinciana • Port Charlotte • Port Orange • Sarasota (3) • Sebastian • Sebring • Spring Hill • St. Petersburg (4) • Stuart • Sun City • Tallahassee (2) • Tampa (3) • Tavares • The Villages (3) • Venice (2) • Vero Beach (2) • Wellington • West Palm Beach • Winter Park • Zephyrhills

For more information on a specific location, please visit FLCancer.com
Partnership with Sarah Cannon Research Institute creates legacy of healing

BY AUDREY POST

It’s a good match. Working with the team at Sarah Cannon gives FCS doctors and patients earlier access to the latest therapies and treatments while they’re still undergoing trials. And while the requirements are much more labor intensive in earlier phases, the rewards are also much greater, according to Katie Goodman, FCS director of clinical research.

“When you’re working in a clinical trial and you can get access to the newest drug for your patient, it’s exciting,” she said. “To see a drug gain approval and be opened to all patients, it makes all the work and all the years to get it there worthwhile.”

It takes an average of five to 10 years to get a new drug approved or an existing drug approved for a new application or diagnosis, Goodman said. A
lot of drugs don’t even make it to patient trials, if lab analysis and animal studies don’t indicate a reasonable chance of success. But the search continues. At any given time, FCS is managing roughly 80 active clinical trials, she said. Because FCS is so large and has multiple locations throughout the state, it can open a smaller trial to help doctors find patients with a specific kind of cancer.

Prior to establishing the partnership with Sarah Cannon, FCS participated in later-phase clinical trials, particularly Phase 2 and Phase 3. While the later-phase trials continue to grow, the practice has also established a Phase 1 program in Sarasota, which is overseen by Dr. Manish Patel, director of drug development at the FCS practice, and Dr. Judy Wang.

“Our practice has grown tremendously over the past few years, with more than 200 physicians and 100 offices in Florida,” Patel said. “We have more than 40 Phase 1 clinical trials actively enrolling here in Sarasota.”

Sarah Cannon has also grown significantly over the past 10 years, and Patel said FCS patients have benefitted from the relationship.

“You have two organizations committed to improving cancer care and being involved in drug development, and both are nationally and internationally known and respected,” he said. “What’s rewarding is being involved in the development of these drugs and their potential positive effects. Everything revolves around patient care in oncology. You get to utilize many practical skills and develop close relationships with patients.”

The Sarah Cannon Research Institute and FCS are both known for expertise with immunotherapy. Patel said that given the fast pace at which the field is growing and evolving, the partnership has created a cutting-edge advantage for both organizations and the patients they treat. The lung cancer drug Opdivo was one of the most recent treatments approved, in part because of the efforts of Sarah Cannon and FCS.

“Sarah Cannon helps match Florida Cancer Specialists to research sponsors and pharmaceutical companies,” Goodman said. “Before that drug was approved, it wasn’t available. But because we participated in the clinical trial, we were able to use it ahead of everyone else.”

That strategy would have appealed to Sarah Cannon herself, who became a passionate advocate for prevention, early detection and aggressive treatment of cancer after surviving breast cancer twice – two mastectomies and reconstructive surgeries as well as radiation in 1985.

Sarah Cannon was created 20 years ago as the global cancer institute of Hospital Corporation of America and named to honor her work. Today, the Sarah Cannon Fund supports the efforts and activities of PearlPoint, a direct services agency providing free cancer support and guidance to adults impacted by cancer anywhere in the U.S. PearlPoint is named for Cannon’s on-stage alter ego, iconic Grand Ole Opry star and country comedienne Minnie Pearl.
Let it be said that, at FCS, maximizing the present means recognizing that the future is now.

It was in that spirit that in 2015 FCS applied and was awarded the right to participate in the five-year Oncology Care Model (OCM), an initiative designed to provide cancer patients with high-quality, highly coordinated care that is ultimately more efficient and cost-effective. As such, it is part of a trend toward value-based care.

“We already had begun transitioning to value-based care, so it was the next logical step for FCS,” said FCS Founder and President, Dr. William Harwin. “We are far better off embracing it and learning how to do it well. The OCM program necessitates additional infrastructure, which costs money, but there is an upside to the program, too.”

That upside benefits both patients and oncology practices.

OCM was rolled out, effective July 1 of last year, by the Center for Medicare & Medicaid Innovation (CMMI). Medicare fee-for-service beneficiaries who are undergoing active chemotherapy treatment are attributable to the program.

The program requires that participating practices supply patients with what CMMI calls enhanced oncology services and what FCS refers to as Care Management.

“Members of our Care Management Team serve our patients as quarterbacks who coordinate their care,” Harwin said.

Those quarterbacks – nurses or personnel operating in collaboration with the physicians and clinical team – are available to patients around the clock, 365 days a year. Many times, they can eliminate what otherwise would be trips to the emergency room.

Care Managers have access to the clinicians who are working with a patient and to the patient’s medical records. They provide patients with a detailed care plan that includes:
- A clear picture of the patient’s condition
- Information about who will be responsible for the various aspects of the patient’s care
- Details about what the patient can expect in the course of his or her treatment

Further, they provide patients with Survivorship Care Plans that include recommended follow-up actions following chemo and suggestions for risk reduction and health promotion.

Harwin added that Care Managers also provide for “medication adherence” as patients move from treatment in a hospital environment to treatment in an office.

Feedback about the OCM program from FCS patients has been positive, said Harwin, who added, “They like having someone to talk to whenever they need to and they appreciate having someone who coordinates their care.”

Participating practices and clinicians are required to treat patients with therapies that conform to nationally recognized clinical guidelines, use data to drive continuous quality improvement, and to use certified electronic health record technology. (That technology was in place at FCS long before it made application to the OCM program.)

Practices that meet OCM requirements qualify for a monthly payment that helps defray the cost for the additional services that the OCM program entails. They may also share in savings when they succeed in controlling costs via the provisions of the program.

Harwin explained that fees for service don’t change in the OCM Model. Rather, OCM is something that is “superimposed” on them.

Practices, Harwin noted, will have the opportunity to “take risk.” If opting to do so, the threshold that they must meet to qualify for share-of-cost-savings payments from Medicare is lowered, but practices, if they fail to meet program requirements, must reimburse Medicare for any increase in cost to Medicare.

How is FCS doing in terms of the OCM program measures? That, at this writing, is an unknown. Practices are compared to a baseline established upon entry to the program and FCS will receive its first set of performance data sometime in March, Harwin explained.

Harwin said it is his responsibility, as the leader of the clinical side of the house at FCS, to shape the practice’s outlook regarding developments such as the OCM program and to ensure that physicians are aware of the program’s expectations.

FCS is prepared to meet those expectations and more by entering into value-based-care agreements with payers in addition to Medicare.

In place is a value-based contract with FL Blue, which is FCS’s largest commercial payer. FCS also has a value-based contract with Cigna and is part of multiple CINs and ACOs.

The future, after all, is now.

FCS embraces Oncology Care Model
Anticipates first set of performance data by Steve Bornhoft
Serious Adverse Reactions

Please refer to the full Prescribing Information for important dose management information specific to adverse reactions.

- **Immune-related pneumonitis.** Immune-mediated pneumonitis or interstitial lung disease have occurred. Fatal cases have been observed in patients with urothelial carcinoma (UC) and non-small cell lung cancer (NSCLC). Permanently discontinue TECENTRIQ for Grade 3 or 4 pneumonitis.

- **Immune-related hepatitis.** Immune-mediated hepatitis and liver test abnormalities, including a fatal case of hepatitis in a patient with UC, have occurred. Permanently discontinue TECENTRIQ for Grade 3 or 4 immune-mediated hepatitis.

- **Immune-related colitis.** Immune-mediated colitis or diarrhea, including a fatal case of diarrhea-associated renal failure in a patient with UC, occurred. Permanently discontinue TECENTRIQ for Grade 3 or 4 immune-mediated colitis.

- **Immune-related endocrinopathies.** Immune-related thyroid disorders, adrenal insufficiency, hypophysitis, and type 1 diabetes mellitus, including diabetic ketoacidosis, have occurred. Permanently discontinue TECENTRIQ for Grade 3 or 4 hypophysitis.

- **Other immune-related adverse reactions.** Meningoencephalitis, myasthenic syndrome/myasthenia gravis, Guillain-Barré syndrome, ocular inflammatory toxicity, and pancreatitis, including increases in serum amylase and lipase levels, have occurred. Permanently discontinue TECENTRIQ for any grade of meningitis or encephalitis, or any grade of myasthenic syndrome/myasthenia gravis or Guillain-Barré syndrome. Permanently discontinue TECENTRIQ for Grade 4 or any grade of recurrent pancreatitis.

- **Infection.** Severe infections, such as sepsis, herpes encephalitis, and mycobacterial infection leading to retroperitoneal hemorrhage, have occurred. Fatal cases have been observed in patients with UC and NSCLC.

- **Infusion-related reactions.** Severe infusion reactions occurred. Permanently discontinue TECENTRIQ in patients with Grade 3 or 4 infusion reactions.

- **Embryo-fetal toxicity.** TECENTRIQ can cause fetal harm in pregnant women. Advise patients of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with TECENTRIQ and for at least 5 months after the last dose.

Most Common Adverse Reactions

The most common adverse reactions (rate ≥ 20%) in UC included fatigue (52%), decreased appetite (26%), nausea (25%), urinary tract infection (22%), pyrexia (21%), and constipation (21%).

In NSCLC (rate ≥ 20%) included fatigue (46%), decreased appetite (35%), dyspnea (32%), cough (30%), nausea (22%), musculoskeletal pain (22%), and constipation (20%).

You may report side effects to the FDA at 1-800-FDA-1088 or www.fda.gov/medwatch. You may also report side effects to Genentech at 1-888-635-2555.

Please see Brief Summary of Prescribing Information on adjacent pages.
TECENTRIQ® [atezolizumab]

Initial U.S. Approval: 2016

This is a brief summary of information about TECENTRIQ. Before prescribing, please see full Prescribing Information.

1 INDICATIONS

1.1 Locally Advanced or Metastatic Urothelial Carcinoma

This indication is approved under accelerated approval based on tumor response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials. [Clinical Studies (14.3)].

1.2 Metastatic Non-Small Cell Lung Cancer

TECENTRIQ is indicated for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) who have disease progression following or during platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving TECENTRIQ. [see Clinical Studies (14.2)].

1.3 Adverse Reactions

See Dosage and Administration (2.2) and Adverse Reactions (6.1).

36.5 months). TSH was elevated and above the patient’s baseline in ≤ 3.3% of patients (range: 0 to 10% across studies).

3.2 Endocrinopathy

Based on its mechanism of action, TECENTRIQ can cause fatal harm when administered to a pregnant woman. Animal studies have demonstrated that inhibition of the PD-L1/PD-1 pathway can lead to increased risk of immune-related rejection of the developing fetus resulting in fetal death. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, advise the patient of the potential risk to the fetus. Adverse events occurring in ≥ 10% of patients treated with TECENTRIQ and not observed in patients treated with docetaxel included: infusion reactions, severe infections, and pneumonitis.

3.3 Meningitis / Encephalitis

Other immune-related adverse reactions including meningoencephalitis, myasthenic syndrome/myasthenia gravis, Guillain-Barre, ocular inflammatory toxicity, and pancreatectomy, including increases in serum amylase and lipase levels, have occurred in ≤ 1.0% of patients treated with TECENTRIQ. [see Warnings and Precautions (5.7)].

4 CONTRAINDICATIONS

No

6.5.2 Hypophysitis

Hypophysitis occurred in 2.5% (1523) of patients with urothelial carcinoma receiving TECENTRIQ. Thirty-eight percent (38%) of patients with NSCLC had Grade 1 hypophysitis. Prolonged hypophysitis may require replacement with corticosteroids. Thyroid function was assessed routinely only at baseline and the end of the study. Monitor thyroid function periodically during treatment with TECENTRIQ. Investigate clinically apparent thyroid dysfunction. Monitor patients for signs and symptoms of hypothyroidism and thyrotoxicosis. Thyroid function should be monitored periodically during treatment with TECENTRIQ. TSH was decreased and below the patient’s baseline in ≤ 3.3% (513) of patients with follow-up measurement.
The most common Grade 3-4 adverse reactions (≥2%) were dyspnea, pneumonia, hypoxia, hyponatremia, fatigue, increased 31 2 9 1

Back/Neck pain 15 2
Arthralgia 14 1

Renal and urinary disorders
Hematuria 5
Hypokalemia 18 2 11 4
Hypophosphatemia 18 4
Anemia 8
Hyponatremia 5
Increased Alkaline phosphatase 4
Increased Creatinine 3
Increased ALT 2
Increased AST 2
Hypobulinemia 1

Musculoskeletal and Connective Tissue Disorders
Back/Neck pain 15 2
Arthralgia 14 1

NSCLC

The safety of TECENTRIQ was evaluated in Study 3, a multi-center, international, randomized, open-label trial in patients with metastatic NSCLC who progressed during or following a platinum-containing regimen, regardless of PD-L1 expression [see Clinical Studies (7.2.9)]. Patients received 1200 mg of TECENTRIQ (n=142) administered intravenously every 3 weeks until unacceptable toxicity or disease progression. Based on animal studies, TECENTRIQ may impair fertility in females of reproductive potential while receiving therapy [see Animal Data (4.9)]. Females of reproductive potential should use effective contraception during treatment with TECENTRIQ and for at least 5 months after the last dose.

6.3 Females and Males of Reproductive Potential

Contraception

Male

Based on animal studies, TECENTRIQ may impair fertility in males of reproductive potential while receiving therapy [see Animal Toxicology (4.7)].

6.4 Pediatric Use

Based on a population pharmacokinetic analysis, no dose adjustment of TECENTRIQ is recommended for patients with renal impairment [see Clinical Pharmacology (12.3)].

6.5 Geriatric Use

No dose adjustment of TECENTRIQ is recommended for patients with mild hepatic impairment. TECENTRIQ has not been studied in patients with moderate or severe hepatic impairment [see Clinical Pharmacology (12.3)].

10 OVERDOSAGE

There is no information on overdose with TECENTRIQ.

17 PATIENT COUNSELING INFORMATION

Adverse events related to the FDA-approved patient labeling (Medication Guide), inform patients of the risk of immune-related adverse reactions that may require corticosteroid treatment and interruption or discontinuation of TECENTRIQ, including:

• Pneumonitis: Advise patients to contact their healthcare provider immediately for symptoms of pneumonia, cough, shortness of breath [see Warnings and Precautions (5.5)].

• Hepatitis: Advise patients to contact their healthcare provider immediately for jaundice, severe nausea or vomiting, pain in the right side of abdomen, or easy bruising or bleeding [see Warnings and Precautions (5.5)].

• Collitis: Advise patients to contact their healthcare provider immediately for diarrhea or severe abdominal pain [see Warnings and Precautions (5.3)].

• Endocrinopathies: Advise patients to contact their healthcare provider immediately for signs of hypophysitis, hyperthyroidism, hypothyroidism, adrenal insufficiency, or type 1 diabetes mellitus, including diabetic ketoacidosis [see Warnings and Precautions (5.4)].

• Menopausal complications, myasthenic syndrome/mysartropathy, and Gullain-Barré Syndrome: Advise patients to contact their healthcare provider immediately for signs of meningitis, myasthenic syndrome/mysartropathy, or Gullain-Barré syndrome [see Warnings and Precautions (5.5)].

• Gastrointestinal Toxicity: Advise patients to contact their healthcare provider immediately for signs and symptoms of colitis [see Warnings and Precautions (5.5)].

• Hepatitis: Advise patients to contact their healthcare provider immediately for signs of infection [see Warnings and Precautions (5.5)].

• Infusion-Related Reactions: Advise patients to contact their healthcare provider immediately for signs and symptoms of infusion-related reactions [see Warnings and Precautions (5.5)].

• Lactation: Advise patients to contact their healthcare provider immediately for signs of rash [see Dosage and Administration (2.2)].

Embryo-Fetal Toxicity

No information on risks to the offspring of animals treated with TECENTRIQ. In non-human primates, TECENTRIQ treatment can cause fetal harm. The risk of causing harm to the offspring of the non-human primate is unknown.

11 PATIENT FAMILIES

Advise female patients not to breastfeed while taking TECENTRIQ and for at least 5 months after the last dose [see Use in Specific Populations (8.2)].

Acknowledgments

The following people have contributed to the writing, reviewing, or editing of this document: Matthew J. Gurney, MD; Lorena E. Cappuccio; and Kishore M. D. Sarma, MD. Parameters were determined under controlled conditions (see Notes).
Look at the group photo taken at the FCS Annual Operations Meeting, held in October, and you can begin to gain an appreciation for the logistics and coordination required to organize the gathering and make it successful.

More than 200 employees including office managers, head nurses, financial managers and senior management team members participated in the seventh annual meeting, which was conducted at Raymond James Stadium in Tampa.

FCS didn’t always require a football stadium as the site for an operations meeting, but, as Chief Operating Officer Todd Schonherz noted, “Our great team gets bigger every year.”

The meeting, he said, represents the one time each year when operations personnel come together to talk about key initiatives for the coming year and discuss “what we need to do to prepare ourselves for the constantly changing landscape of community oncology.” While the meeting examines, certainly, how FCS is doing relative to established objectives, the emphasis is on what’s next.

“We need to continue to find ways to drive operational efficiency in all of our clinics through initiatives including patient self-service,” Schonherz said, “and better enhance our value proposition to the benefit of patients, employers and insurance companies.”

Doing so has come to involve the value-based care rollout at FCS and the related care management initiative. Schonherz called the introduction of value-based care the single biggest change introduced at FCS in the last year.

Schonherz was quick to add that securing the future also
means investing in employees to ensure that they have the tools and skills they need to be successful and take their places as organization leaders.

Schonherz cited FCS University as an example of such investment. The e-learning platform enables FCS to deliver relevant and timely content to employees—clinical content for nurses, pharmacy techs and medical assistants and also professional development content, including information on how to manage a difficult situation or conduct an effective interview.

While meeting participants hear presentations from FCS employees, Schonherz also makes it a point to bring in an outside speaker with a different perspective.

In October, that speaker was Don Yaeger, a cancer survivor, author, motivational speaker and former associate editor at Sports Illustrated magazine.

Yaeger described encounters with NBA great Michael Jordan and his interactions and encounters with legendary coach John Wooden. Schonherz said Yaeger and his message on how to overcome adversity were extremely well received by his FCS audience and, based on evaluations, Yaeger was the most highly rated speaker to address an Annual Operations Meeting.

The conference was not without some fun in the form of a team-building exercise. Each team was made up of employees from around the state, ensuring that participants were joined with people with whom they don’t usually work.

The exercise required teams, under deadline pressure, to communicate effectively and build a miniature golf hole.

“It mirrored what we do on the job,” Schonherz said. “We work collaboratively under challenging circumstances. And we can’t afford for anyone or any department to work in a silo.”

After the teams combined to build a miniature golf course, participants played the layout, a winning team was determined and a donation of more than 1,000 pounds of food was made to a Tampa-area food bank.

“The meeting is a big commitment on the part of the organization,” Schonherz said. “It takes a lot for everyone to attend. We appreciate the support of executive management and we are grateful to our physicians for making it possible for the meeting to occur.

“We appreciate everyone’s participation and plan to hold the meeting in years to come.”
Anne Ronco is about to kick it up a notch in Lee County. Recently, the health care administrator was promoted from Senior Office Manager of the Gladiolus Office to Associate Regional Director of several offices in the Lee County region, including Gladiolus, Cape Coral/Cay West and Colonial. She will also oversee a new building in Cape Coral/North Fort Myers in the summer.

Ronco, who began working at Florida Cancer Specialists (FCS) Research Center 18 months ago, has worked in health care administration for her entire 20-year career. Prior to FCS, she worked with Cogent Healthcare System in Fort Myers, where she has lived for 20 years with her husband, Steven, and two sons, Christopher and Landon.

The fast pace in FCS clinics and the practice’s high expectations suit this high-energy Floridian, who says she thrives on pressure and attacks cardio kick-boxing classes several times a week.

“I love that this job challenges me continuously,” Ronco says in an interview at the Gladiolus office. “I’m a pusher and a driver. I welcome the challenge, and I’m grateful FCS has enabled me to grow and explore my potential.”

In her role as Associate Regional Director, Ronco will be tasked with making sure the daily operations of all of the office locations in the region run smoothly. Her plan is to work out of the Gladiolus office three days a week and spend the other two days traveling between the other three offices in an effort to connect, in person, with staff.

“Transparency is where it’s at,” she says. “People need to know I’m real and I’m there for them. I plan to invest a lot of time at the clinics, being on hand for them. I cannot be a great manager unless I understand the issues, and the only way to do that is to be there.”

Ronco’s management style is to hold meetings in order to listen and learn and then progress from there. Her job is to oversee hiring and training, the development and implementation of best practices, and patient satisfaction.

“Patient satisfaction moves the gears that drive all we do,” Ronco says. “And that’s great, because my favorite thing is customer service, and I really want to drive that home.”

Ronco plans to provide the training and tools needed to help staff understand how to successfully engage with patients. She will discuss everything from the dress code to greeting and checking in
patients to working with patients as they embark on their journey with FCS. Each effort and touch point will be evaluated, monitored and tightened up, where necessary.

“Improving our patient satisfaction is living up to our commitment to our patients,” she says. “In some areas, we just need to bring it back to what we know works: manners, eye contact, calling them by name. And it all goes back to the front desk, so that’s what I want to start with.”

For Ronco, it’s personal. Her grandmother died of cancer. Ronco believes that patient care all comes down to the Golden Rule. “I always go back to the saying that I want patients to be treated as if they are my family,” she says. “I always think of that and always remind the staff of that.”

Ronco advanced in FCS rather swiftly, but she didn’t do it alone. She credits two leaders with helping her find her way: Dr. William Harwin, the founding physician for FCS, and Lois Poel, Associate Regional Director for Collier County.

“I am amazed at Dr. Harwin,” she says. “He’s a workhorse. He’s always respectful and he’s always willing to educate me to help (me) understand things better.” Ronco then describes Poel as “a genuine mentor who always goes above and beyond.”

Cultivating relationships is one thing that both of Ronco’s mentors have instilled in this rising leader. “We all know we get further with lemonade than lemons,” Ronco quips.

Being located near the company headquarters is an opportunity that is not lost on Ronco. “Fort Myers sets the standard and there are a lot of resources here,” she says. “It’s exciting to me that a lot of what happens in FCS begins right here, in Lee County.”

Ronco is also excited to be a health care director during the most dynamic time in the industry’s history. “Changes are happening at whirlwind speed … (and) that’s what I like about health care,” she says. “Here at FCS, we are moving from volume to value, and that means opportunities for all patients. It’s a great time to be involved, for sure.”
1. **FCS FOUNDATION VOLUNTEERS’ SERVICE AWARDS**

1A. Margaret Weatherby and Susan Southwick were honored for two years of volunteer service as patient support volunteers at the Tampa Cancer Clinic.

Pictured (L-R): Helga Von-Grieff, Monica Tyler, Margaret Weatherby, Susan Southwick, Tammy Harden, Sam Watkins. Not pictured: Natasha Kress Johnson was honored for one year of service.

1B. The FCS Foundation volunteers at the Paylor Lane office in Sarasota were honored for their one-year of service at a luncheon in January.

Pictured (L-R): Val Vance, Executive Director, FCS Foundation; Mike Hibnick, volunteer; Bruce Colby, volunteer; Jo Kleindienst, volunteer; Connie Thompkins, volunteer; Lynn Rasys, Volunteer Program Manager, FCS Foundation

1C. Nick O’Connor was presented with his one-year AND two-year service award pins and certificates at the FCS Foundation office on January 25. Nick is one of the original Foundation volunteers.

1D. Six volunteers were honored for their one-year of service on February 3 at FCS Sarasota Downtown.

Pictured (L-R): Maggie White, Bill Stollon, Sharon Marks

Not pictured: Sue Brown, Marie Guillet, Carolyn Jacobson

1E. Jane Welsh and Terri Prechtl were honored for their one-year of volunteer service at the FCS Lakewood Ranch clinic on January 9. Both received a certificate and a one-year pin.


Front: Jane Welsh, Terri Prechtl, Lynn Rasys, Trudy McDonald, Sonya Miller RN, Jade Valencia RN, and Shelly Glenn

1F. Volunteers were honored for their one-year of volunteer service at a breakfast on Wednesday, February 22 in Port Charlotte. The Patient Support volunteers were presented with a one-year service pin, certificate and gift bag.

Honorees: Allie Agee, Shirley Crane, Barbara Farlow, Mary Sudyka, Judy Western, Linda Wilson

Pictured (L-R): Allie Agee, Mary Sudyka, Barbara Farlow, Lynn Rasys (Volunteer Program Manager, FCS Foundation), Tammy Bennett (Office Manager/Head Nurse), Linda Wilson
2. HOLIDAY PARTY IN ORANGE CITY
Employees in Orange City dressed in their best ugly sweaters, participated in a tasty cookie exchange and organized a canned food drive for patients.

2A. Sandra Santiago
2B. Pictured (L-R): Ashley Jackson, Carol Carvajal, Michelle Cook and Brook Dees
2C. Pictured (L-R): Dannette Ball, Jennifer Smith and Michelle Cook

3A & 3B. FCS VOLUNTEERS’ HOLIDAY PARTY IN WELLINGTON
**4. HEART OF FLORIDA HOLIDAY PARTY**

Congratulations to Dr. Susan Ross, who received the Doctor of the Year Award at the Heart of Florida event.

Pictured (L-R): Adam, her nephew; Dr. Susan Ross; Kay Simpkins, Associate Physician Liaison; and her son David.

**5A & 5B. PATIENT APPRECIATION HOLIDAY PARTY IN ORMOND BEACH**

**6. PATIENT APPRECIATION LUNCH**

Doctors Geetha Kamath and Ananth Iyer participated in a patient appreciation holiday lunch held on Friday, December 2. Over 150 patients and their families attended.

**7. CONGRATULATION TO DR. PARESH PATEL - REAL MEN WEAR PINK TOP 5 FUNDRAISER WINNER**

Combined, the 2016 Real Men Wear Pink community leaders raised $24,000 for Making Strides Against Breast Cancer. Dr. Paresh Patel represented FCS in raising $1,820!
8. THE HOLIDAYS AT DCC
Pictured (L-R): Michelle Russo RN, Ashley Glass Hooks RN, Amy Youman RN, Dr. Mudussara Khan

9. FLASCO LIVING WITH BREAST CANCER
Dr. Scott Tetreault spoke at the Capitol during the FLASCO Living with Breast Cancer event about treatment options and the role of the community oncologist.

10. TREASURE CHESTS 5K CHECK PRESENTATION AT RAYMOND JAMES STADIUM FOR THE TAMPA BAY BUCCANEERS GAME
Pictured (L-R): Brian Adams - CEO of Florida Hospital Tampa, Samantha Watkins - Regional Director of Florida Cancer Specialists, Darcie Glazer Kassewitz - Glazer Family Foundation Co-President, Mallory McLean - Community Manager, Making Strides Against Breast Cancer Florida Division American Cancer Society, Inc. and Susan Stern - VP Moffitt Cancer Center Foundation

11. LOCAL GIRL SCOUTS IN PORT CHARLOTTE DISTRIBUTING PATIENT GIFT BAGS
Girl Scouts Pictured (L-R): Malani Taylor-Whidden, McKayla McComiskey, Michelle Rambo, and Jordan Moran
FCS Nurses Pictured (L-R): Heather Williams RN, Teresa Bowers RN, Holly Bjerkness RN, Tammy Bennett RN, Amy Green LPN, Nancy Snow RN

Submit your recent event photos to FCS Marketing at marketing@FLCancer.com.
There is no I in Team

BY TISHA CREWS KELLER
Jeff Rubin loves his job. He’s not stuck behind a desk, typing emails and pushing papers all day. Instead, he’s out in the field, juggling his workload and electronic devices to stay connected somewhere between Pinellas County and Tallahassee, visiting one of the 26 FCS clinics he oversee.

Rubin’s goal each day is to fix challenges and strategically plan for the needs of the clinic and operations of the staff he oversees. Patient concerns and compliments, as well as staff concerns, go to Rubin for assessment and correction or facilitation—and he’s happy to be the transistor in the FCS network.

As Vice President of Practice Operations, Rubin describes his role as a go-between for daily operations and the functions of clinics located within Pasco, Pinellas, Hernando, Citrus, Alachua, Marion and Leon counties. With Regional Director Samantha Watkins (Hillsborough County) and Regional Director Eric Grindstaff (Charlotte, Sarasota, Manatee, Highlands, Polk and Osceola) directly reporting to Rubin, he also has for overseeing the operations in these areas.

“I want to see what the patient sees,” he says. “I always enjoy greeting the staff and visiting with the office managers and head nurses to discuss what will help them work better and more efficiently.”

He works with the physicians and their extenders (physician assistants and nurse practitioners), clerical, nursing and pharmacy professionals to ensure that their needs are met and patient care is optimized.

This may include addressing patient flow and adding ancillary/supportive services, such as nutritionists or massage therapists. These services help provide patients with a holistic approach to tackle cancer care.

On the administrative side, 17 FCS office managers and two directors of operations report directly to Rubin. He’s constantly working with staff to coordinate functions and eliminate silos—all of which he directly correlates with improved patient care and outcomes. When Rubin pays a visit to an FCS clinic, issues such as staffing concerns and community-partner relations are all addressed.

“One of my main goals is to give our employees—whether they are clinical or administrative—more time to focus on patient care,” he explains.

In Rubin’s mind, patient care begins as soon as the patient is referred to any FCS location.

He works closely with Senior Management and the Operational Excellence team on many projects, which FCS holds in high regard. These projects begin small but quickly disseminate to all clinics when they are fruitful—something Rubin is always hoping will be the case.

These projects begin small but quickly disseminate to all clinics when they are fruitful—something Rubin is always hoping will be the case.

As Vice President of Practice Operations, Rubin describes his role as a go-between for daily operations and the functions of clinics located within Pasco, Pinellas, Hernando, Citrus, Alachua, Marion and Leon counties. With Regional Director Samantha Watkins (Hillsborough County) and Regional Director Eric Grindstaff (Charlotte, Sarasota, Manatee, Highlands, Polk and Osceola) directly reporting to Rubin, he also has for overseeing the operations in these areas.

“I want to see what the patient sees,” he says. “I always enjoy greeting the staff and visiting with the office managers and head nurses to discuss what will help them work better and more efficiently.”

He works with the physicians and their extenders (physician assistants and nurse practitioners), clerical, nursing and pharmacy professionals to ensure that their needs are met and patient care is optimized.

This may include addressing patient flow and adding ancillary/supportive services, such as nutritionists or massage therapists. These services help provide patients with a holistic approach to tackle cancer care.

On the administrative side, 17 FCS office managers and two directors of operations report directly to Rubin. He’s constantly working with staff to coordinate functions and eliminate silos—all of which he directly correlates with improved patient care and outcomes. When Rubin pays a visit to an FCS clinic, issues such as staffing concerns and community-partner relations are all addressed.

“One of my main goals is to give our employees—whether they are clinical or administrative—more time to focus on patient care,” he explains.

In Rubin’s mind, patient care begins as soon as the patient is referred to any FCS location.

He works closely with Senior Management and the Operational Excellence team on many projects, which FCS holds in high regard. These projects begin small but quickly disseminate to all clinics when they are fruitful—something Rubin is always hoping will be the case.

Recently, self-check-in kiosks made their debut at select FCS locations, and Rubin hopes the kiosks will soon serve additional sites. With this innovative check-in system, patients use an electronic tablet to confirm or edit their personal information as soon as they arrive. This streamlines the process by leaving front desk staff open to talk with patients and solve more complex issues as they arise and its hopeful that this new technology will help in other areas such as improving first pass rates with insurance claims.

In FCS, mergers and acquisitions are key to what we do. Rubin has assisted in many mergers and acquisitions. Coming to FCS from a merger himself has helped him better prepare staff for the transition. Mergers are a very demanding time for the doctors and employees joining FCS and having an understanding of what they are going through gives an opportunity to help ease some of the anxiety.

With clinics spread around the state, Rubin is “on the go” up to 75 percent of the time. He’s based in the FCS Highland Clinic, and he is lucky to have a territory that covers a large geographic area but allows him to be home most evenings.

His wife, Susan, and three young children (Rachael, 10; Jacob, 7; and Gabriel, 4) appreciate that about his job.

After having taken time off from work for their young family, Susan will soon be back in the classroom as an elementary educator. When not working or at school, the family is likely on the soccer field, at a dance or drama performance, spending time together outdoors or enjoying a movie night.

Before becoming Vice President of Practice Operations in 2015, Rubin was Senior Regional Director of FCS, supervising and coordinating FCS clerical, nursing, laboratory and pharmacy personnel in his current territory.

His early career was in the pharmaceutical field as a Sales Manager and Certified Pharmacy Technician.

He began with FCS in 2003, when he joined Oncology Physicians as Pharmacy and HR Manager. He was then promoted to Office Manager, a position wherein he supervised all personnel.

This experience gives Rubin an insight of what nurses and pharmacy technicians go through on a daily basis, and he truly believes that this is important to his success.

This valuable insight lends itself to Rubin’s management style, which is to talk with staff and bridge gaps between departments.

“We are all important and integral to patient care,” he explains. “I want to help create a work environment for our staff that is fair, honest and collaborative. The more we all know, the stronger our team is together.”

In the same vein, Rubin attributes his success to the support and efforts of the Senior and Executive Management at FCS: There’s nothing he can do alone to make care better for patients. Emphasizing the team effort and recognizing that every person is part of the whole is what makes FCS a remarkable organization. It is also what allows FCS to realize this overarching goal at all levels: Do the very best for the patients.

For Rubin, the goal is also very personal.

“What I most enjoy about FCS is the fact that what we do for a living—in the oncology field—cannot be matched,” he says. “Making our patients smile and laugh during a challenging time is worth the effort. And wonderful doctors and staff make it all possible.”
Q&A Profile
get to know your doctor

Get to know

Dr. Jim Reeves answers some of our questions

You joined FCS in 1988. What are the greatest changes – apart from its tremendous growth – that you have observed in the organization over the past 28 years?

I remember fondly the days when Bill Harwin, Tom Teufel, Lowell Hart and I would sit around Bill’s desk and make decisions for the practice, for better or worse. My favorite anecdote was when we seriously debated whether to get a fax machine or not, and had to call Danny Dosoretz to help decide! We eventually got the machine. It became increasingly clear even at that time that Bill had the vision to make our practice successful, not only in terms of medical excellence, but also in the business of medicine.

The greatest change, in my opinion, is when we formed a professional administration to run the practice. In the early days, I think it was harder for us to understand how an MBA chief executive would help us than how that a fax machine would help us. Now, 28 years later, I don’t think any of us would be able to be successful without our administration team to manage personnel, mergers, drug purchasing, IT, government regulations, and all the other things Brad Prechtl and his team handle, so we doctors can focus on practicing medicine and research. I am very thankful that my partners on the executive committee are so involved in making strategic decisions for our practice. Like Bill Harwin, these doctors have a special skill set to integrate the best of medical and business practice.

Discuss the importance of clinical trial research to FCS. How are candidates for participation in trials identified?

Clinical trials are the way in which advances in treatment are made. I am proud that FCS is playing a role in development of so many new drugs. Through these efforts FCS can continue to help improve the life and health of people with cancer and blood disorders.

Participation in clinical research improves treatment for our current and our future patients. Often, the only way for a patient to receive a new, effective drug is to participate in research. Research trials test new concepts, such as the addition of CDK4/6 inhibitors to hormone therapy in breast cancer, or the addition of immunotherapy to chemotherapy in lung cancer. A physician participating in a trial learns new concepts about mechanisms of disease and how to integrate new classes of drugs into standard practice.

Patients for trials are identified by their diagnosis and prior treatment for eligibility. Then the patient must meet all the eligibility requirements for the trial and formally consent to participation. I am working to try to find ways to better identify research candidates for clinical trials in OncoEMR and through other databases. This process is difficult with lots of pitfalls along the way. One often reads the lament in the lay press that “only 3% of cancer patients participate in research trials.” After working in this field for many years I often think that 3% is pretty good!

As a researcher, you have dealt with a wide range of cancers. What are the common denominators among cancers? We often hear about efforts to “find a cure for cancer.” Is it possible that a broad-spectrum cure will be developed or is it more likely that individual cancers will require unique solutions?

Cancer arises from a series of genetic mutations that conspire to drive the cancer cells to become immortal and ignore the control mechanisms regulating cell behavior. These “driver mutations” can be targeted by drugs but there are many different ones that may be involved in a particular cancer. Therefore, different cancers respond to different drugs.

We often hear about a future “cure for cancer,” but I think it is important to emphasize that many, and perhaps most, cancers are curable right now, mainly by early detection. Mammograms, colonoscopies, routine exams, screening CT scans in smokers are
all important in finding cancer at a point where it can be cured. It is, of course, better for the patient if he or she never gets cancer, so the importance of proper diet, exercise, smoking cessation, and avoidance of environmental causes cannot be overemphasized.

I think a broad-spectrum cure for cancer is possible. This will likely involve improvements in immunotherapy treatments. I think we are in about the “2nd inning” of the game to maximize these treatments. To date, we have drugs that address the PD1-PDL1 immune pathway and the CTL-4 pathway. I heard recently that there are 26 other immune pathways relevant to cancer control! Already, FCS is participating in trials to enhance the response of cancer cells to these treatments.

Manish Patel and Judy Wang at our DDU in Sarasota have access to experimental drugs addressing other immune pathways. Exploring this will require many research trials and is the reason FCS doctors should participate in their own locations and by sending patients to Sarasota when appropriate.

Give us the good news where oncology research is concerned. Describe for us an advance that you helped bring about and how you got there.

The most gratifying aspect of my medical practice is when I see a patient benefitting from a new, experimental treatment that would not be available to that patient outside a research trial. A good example is a patient of mine who presented several years ago with metastatic breast cancer to the liver. Her anticipated survival would have been 1-2 years. If treated with “standard” treatment, she would likely get a series of chemotherapy drugs, with the attendant side effects. She entered a research trial, called the Cleopatra trial, using pertuzumab along with other drugs. At the time pertuzumab was experimental. She has had a great response and continues on pertuzumab with minimal evidence of cancer and essentially no side effects. Pertuzumab got approved by the FDA largely due to the results of the Cleopatra trial and now is benefitting many patients. This is a “win” for her, for breast cancer patients, and for society at large. At the risk of seeming melodramatic, there is a song I hear in my heart every time I see her in the office.

Tell us about the role you play in connection with the FCS Foundation and the differences that the Foundation makes in the lives of patients.

FCS has a spectacular foundation that is so vital for helping our patients and their families at the time of most need. We are fortunate to have Shelley Glenn and her team to organize such wonderful events for us. My role is simply to support these efforts, and I think all FCS doctors should.

You see patients in addition to conducting research. How does contact with patients make you a better researcher?

I feel fortunate that I get to see a broad spectrum of hematology and oncology diagnoses. It is important in my view to see and appreciate the usual clinical course of a disease process as it helps to understand the impact of a new experimental approach to treatment. When deciding on a new course of treatment I always view a research trial as another option for the patient’s treatment. If the patient is eligible for the trial, this is usually the best option since most trials at FCS compare the best standard treatment to an experimental treatment we think may improve on the standard.

You went to school at LSU. Did you grow up in Louisiana? What makes for the best of crawfish boils? If you were limited to one seafood spice and it could be only Old Bay or Cavender’s, which would you choose?

I grew up in Shreveport, in the Bible Belt in north Louisiana. It was quite an education to go to LSU in Baton Rouge, and later to LSU Medical School in New Orleans. There, I got exposed to the wonderful south Louisiana culture. I am partial to Zatarain’s Crab Boil but the others are fine. The best crawfish boils involve a good recipe (best left to the professionals) enjoyed with a lot of fun-loving people, your libation of choice, and good Cajun music.

The best hot sauce on the planet is what?

Tabasco, made at Avery Island, Louisiana.

Tell us about your family. How do you succeed in balancing work and home?

My lovely wife, Lea Ann, and I have two boys, Drew and Brian. Drew works at Merrill Lynch in Jacksonville and Brian is entering his last semester in college at LSU. The boys were both very active in sports so our “home” life used to involve a lot of nights and weekends at the ball park or basketball court. Sometimes I wonder how we survived all that with my work schedule. Life is a little less hectic now that they are grown but I still seem to have more on my plate than I can get done at the office and with research.

What was the last great idea that occurred to you like a bolt from the blue in the middle of the night?

In summer 2015, I made a decision to retire from FCS on my 61st birthday in November 2016 and gave my required year’s notice. At the 2015 FCS summit in Orlando, while listening to the presentation from the research team at Sarah Cannon I realized how exciting cancer research is going to be in the next few years. The “bolt from the blue” that struck me was that I needed to find a way to continue in research. I discussed this with Bill Harwin and Brad Prechtl. Frank Rodriguez was also very helpful in fashioning a plan where I can have a more limited office practice with more time devoted to research.

I plan to help find ways to increase accrual to research trials across all of FCS so more patients can benefit and new treatments can develop. To date, it has been harder than I thought to pare my practice down to size to permit this.

Complimentary front-row tickets at an Aaron Neville concert or a Harry Connick Jr. concert. Which appeals to you the most?

Aaron, no question. Some of my fondest memories are of seeing Aaron with his brothers, the Neville Brothers band. After a busy med school week in the early 80s, a bunch of us would go to Tipitina’s to see them rock the joint until the wee hours. We were all a lot younger then!
Jennifer Baptiste was destined for nursing. Growing up in Trinidad & Tobago, she was inspired by two aunts and a grandmother who were nurses. “I always knew I wanted to be like them,” she said.

Now Head Nurse at Florida Cancer Specialists’ Tavares office, her extensive experience as a skilled, hands-on oncology nurse and in management create the perfect environment to “pay it forward” and inspire others. Many FCS nurses from other offices, including newly promoted head nurses, are sent to the Tavares office for training.

“I had great mentors and I have tried to be one, too,” Baptiste said. “I’ve been blessed to travel this road and see the great strides in oncology. I feel like I’ve contributed a lot, and I’ve learned a lot from my patients.”

After moving to the U.S. as a teenager, Baptiste studied nursing at City College of New York, earning a bachelor’s degree in 1979. She worked in New York, Massachusetts and Tennessee over the next 25 years, in both hospitals and in private practice. Early in her career, she was deeply moved by a cancer patient in her care, and her love of oncology continued to grow. She got her oncology nurse certification in 1989 – only the fourth year it was offered – and she has earned renewal every four years, with exams until 2005 and with continuing education units since then.

“FCS encourages all oncology nurses to be certified and also rewards it,” she said. “Plus, you get to wear it on your nametag, which tells the patient you’ve gone the extra step.”

She moved to Florida in 2005 to be closer to her aging parents in Orange County, joining the staff of what was then called Lake County Oncology. In 2011, the practice merged with FCS whose highly structured operation appeals to Baptiste’s sense of order.

“I’m a little bit of a disciplinarian,” she admitted, chuckling. “A couple of the nurses call me a ‘drill sergeant,’ but I know they mean it well.”

For 7 years, Baptiste was staff facilitator for the Tavares-area Leukemia and Lymphoma Society, which met monthly. Currently, she serves on the FCS’ Clinical Direction Team, a policy and procedures advisory panel composed of 21 members from all specializations involved in the process of policy/procedure development and reinforcement. She considers it an honor to have been chosen. Todd Schonherz, Chief Operating Officer, praised Baptiste’s commitment and contribution.

“She has certainly proven to be a valuable member of the team,” Schonherz said. “She integrates the work she does at the clinical level with her patients.”

About a year and a half ago, the disease Baptiste has spent much of her life fighting struck her own family. Her brother, Ric Fisher, was diagnosed with Stage 4 esophageal cancer in October 2015. Nineteen years older than he, Baptiste had always been a mother figure as well as a sister to him; she then added “nurse” to the list of relationships. She got Fisher to Florida from North Dakota, where he’d been working in the oil fields, and FCS Dr. Ralph Gousse saw him. Fisher died the following Jan. 1, the day after hospice brought him home.

Baptiste is grateful for her colleagues’ support during that very difficult time and said she got through it because of her faith and the opportunity to make sure her brother got the very best care possible. “It was the hardest thing, but it really helps you understand what a family’s going through,” she said. “I’m glad I was still working and able to take care of him myself.”

Patient care remains her top priority, whether it’s tending to her patients’ physical needs or their mental or spiritual ones. “They all leave their mark on you. I have a patient now who is the age of my late brother, and we have bonded. He knows his disease is not curable. He asked me to pray with him. I do.”

Every evening, she goes for a walk with her husband, Frank Baptiste, and they share the highlights of their day. “I reflect on what I could have done better or said better,” the head nurse said, “and I resolve to do so the next day.”
Dr. Jorge Ayub
Creating human bonds that go beyond being a doctor

Dr. Jorge Ayub grew up with his twin cousins in a small town in the south of Brazil, just across the river from Argentina. His family has always been close; in fact, he still gets back to Rio Grande Do Sul to visit his 90-year-old mother at least once a year.

When Dr. Ayub reflects on his 30-year medical career as a hematologist and oncologist, his thoughts go back to his hometown … and to his uncle, a physician who handled everything from surgery to obstetrics to minor trauma treatment. Young Jorge saw how his respected uncle helped people in his community, and he wanted to do the same.

“It was how he was brought up.

“I was raised in a family that instilled in me family values and a love for fellow human beings that you carry along throughout your life,” Dr. Ayub says.

Not only did his uncle provide him with inspiration, but he also gave his nephew the necessary financial support to send him through a six-year program following his high school graduation. He thrived in his courses and then entered medical school at the University of Rio Grande Do Sul in Brazil, after which he completed an internship at Mt. Sinai Medical Center in Miami Beach and a residency at University of Miami at Jackson Memorial Hospital, where he was part of a special initiative to train Latin American physicians.

During summer vacations, Jorge would return to South America and work alongside his uncle gaining invaluable “real world” experience. “I would round with him and scrub in on some surgical

BY ZANDRA WOLFGRAM
cases and work in the O.R. It was a small town and there weren’t a lot of controls, so you had the chance to be hands on,” he says.

The young medical student thought he would pursue a surgical specialty, but when he began his clinicals, that all changed. “I cherished the thinking, the challenges and the patient contact,” he says. “And so I pursued internal medicine.”

It has been five years since Dr. Ayub joined Florida Cancer Specialists and, today he feels at home in the practice’s culture, seeing patients in Hudson, Land O’ Lakes and New Port Richey. Also, Dr. Ayub reviews all new drugs that are approved and, with the help of the FCS team, creates a menu for the FCS physician library to be utilized by the doctors.

He appreciates the advantages of being a partner in Florida’s leading community oncology practice.

“With the support of Florida Cancer Specialists’ management team, our physicians are free of the administrative burden, so that we can concentrate on what is most important, patient care. Also, I value the scientific expertise as well as other interactions with my colleagues. It’s very dynamic . . . ”

The FCS patient care philosophy also fits Ayub’s approach to medical care. “My philosophy is to have respect for the patient as a human being,” he says. “Every step I take on that journey, I want to ensure they have the best information . . . so they can make the best decisions.”

Ayub is adored by his patients, in part, because he is relatable. “I am very direct, but I am also plain-spoken,” he says. “I use a lot of humor and when I step into that room and close the door, the first thing I want to do is connect on a personal level. … I try to create a bond that goes beyond being a doctor.”

It’s these personal, deeply human connections that keep Ayub going. “I love medicine,” he says, “but it’s the interaction with the patients, beyond any other aspect, that makes it worth the long hours for so many years.”

And it’s his patients that he keeps in mind when he works in his various FCS leadership roles, which include appointments to the Board of Directors, which reviews all incoming physicians, and the Quality Committee, which creates all FCS drug protocols — a responsibility to which he devotes at least a few hours each day.

Ayub is tasked with researching, gaining approval for and overseeing the mechanics of inputting each customized drug regimen that is not on FCS’ software menu. Over the years, FCS has built a library of drug protocols, but that library has to be constantly reviewed and updated. “We just went through the oral medications from A to Z to look at what we originally had and determine if it was still valid,” he explains.

Ayub enjoys the attention to detail and says that designing drug protocols keeps him on his toes. “If you are not willing to keep up with the industry and your knowledge, you will not be a good doctor, especially in this area,” he says. He points to a recent study that said that if trained physicians were to stop reading medical journals and attending workshops and meetings on medical subjects, they would lose 50 percent of their knowledge in five years.

Beyond mental fitness, Ayub keeps active by running at least three times a week to stay physically fit, too. He takes fishing trips as often as he can — the more remote the location, the better. And he spends time with his wife, Margareth, their daughter and three sons and their two young grandsons, who all live in Florida.

Health care is definitely changing, and there are many changes to come; but Dr. Ayub is ready to take on any challenge. He’ll do it in the same way that he approaches everything else . . . with a human touch.

“If anyone can be successful in the new reality we all face, FCS will be,” he says. “But it will require a commitment from everyone — as a group.”
Myriad is ION’s Preferred Partner for Best-In-Class Hereditary Cancer Testing & Services

Myriad provides a suite of solutions to allow you to confidently manage your patient’s comprehensive cancer risk based on your practice’s needs.

**Preferred Partner Services**

- Various hereditary cancer test options
- Patient screening and identification tools
- Medical support services
- Clinical genetics education for physicians, APPs, and staff
- Patient financial assistance programs
- Practice-specific test ordering processes
- Patient support services

For more options contact your ION Strategic Account Manager or your local Myriad representative

**MYRIAD myRisk**

Myriad myRisk® hereditary cancer panel identifies patients at an elevated risk for cancer by analyzing 28 clinically significant genes associated with 8 important cancer sites.

The myRisk report includes the genetic test result and a comprehensive summary of medical society guidelines to inform your treatment decisions and optimize care.

For More Information About myRisk Visit MyriadPro.com or Download the myRisk App
Answers to the Most Frequently Asked Benefit Questions

What is a Deductible?
A deductible is the amount of money you or your dependents must pay toward a health claim before your organization's health plan makes any payments for health care services rendered. For example, a plan participant with a $100 deductible would be required to pay the first $100, in total, of any claims during a plan year.

What is a Copay?
In health insurance a copay (copayment) is a fixed amount you pay for covered services, typically when you get the service. Copays differ from coinsurance (the percentage you pay for covered services, usually after reaching your deductible).

What is Coinsurance?
On top of your deductible, coinsurance is a provision in your health plan that shows what percentage of a medical bill you pay and the percentage a health plan pays.

What is an Out-of-pocket Maximum (OOPM)?
An OOPM is the maximum amount (deductible and coinsurance) that you will have to pay for covered expenses under a plan. Once the OOPM is reached the plan will cover eligible expenses at 100 percent.

What is an Explanation of Benefits (EOB)?
An EOB is a description your insurance carrier sends to you explaining the health care benefits that you received and the services for which your health care provider has requested payment.

What is a Preferred Provider Organization (PPO)?
A PPO is a group of hospitals and physicians that contract on a fee-for-service basis with insurance companies to provide comprehensive medical service. If you have a PPO, your out-of-pocket costs may be lower than in a non-PPO plan.

Confused about common health insurance benefits terms? These FAQs cover the basics to take the mystery out of coverage terms.

What is Utilization Management (UM)?
Utilization Management is the process of reviewing the appropriateness and the quality of care provided to patients. UM may occur before (pre-certification), during (concurrent) or after (retrospective) medical services are rendered.

For example, your health plan may require you to seek prior authorization from your UM company before admitting you to a hospital for nonemergency care. This would be an example of pre-certification. Your medical care provider and a medical professional at the UM company will discuss what is the best course of treatment for you before care is delivered. UM can reduce unnecessary hospitalizations, treatment and costs.
The FCS Foundation fulfills a unique purpose for cancer patients who are struggling to pay their everyday living expenses. Imagine cancer patients who can’t make car payments leaving them without transportation to their physician’s office; or patients who can’t pay mortgage or rent and are facing eviction while they are fighting for their lives. The Foundation pays for non-medical expenses such as mortgage, rent, utilities and car payments, so that patients can concentrate on recovering from cancer.

What Separates the FCS Foundation from Other Charities?
Florida Cancer Specialists pays the overhead, which means that **100% of all donations go directly to help cancer patients in need!** The FCS Foundation provides help for the entire family, as well, by relieving some of the stress cancer patients and their family members face on a daily basis.

You Can Make a Difference. Volunteer.
The Florida Cancer Specialists Foundation is seeking volunteers to provide non-medical support and comfort to patients undergoing treatment for cancer at Florida Cancer Specialists clinics. Duties include offering a pillow, warm blanket, snack or beverage to the patient, sharing a magazine and providing companionship.

Applications are available at Foundation.FLCancer.com/Volunteer or send email inquiries to: VolunteerProgram@FLCancer.com

Thank You for Your Continued Support of the FCS Foundation!

For more info or to donate, call (941) 677.7181 or visit Foundation.FLCancer.com