White & Brown Bagging
Community Oncology Alliance Position Statement

Community Oncology Alliance Position:
The Community Oncology Alliance (COA) opposes the processes known as “white bagging” and “brown bagging” because the safety and integrity of the medication is not assured thereby jeopardizing highly individualized patient treatment protocols and ultimately patient prognosis.

Background:

White and Brown Bagging are an Increasing Trend in Oncology
Many practices are forced to obtain drugs through specified mail-order companies as dictated by the pharmacy benefits of patients’ policies rather than a direct purchase by the practice. These medications are shipped to the physician’s office in a process known as “white bagging” or directly to the patient, in a process known as “brown bagging,” who then take the medication to their oncologist to be administered.

About one-fourth of drug volume for in-practice use in 2014 was purchased by specialty pharmacies and supplied to practices via white and brown bagging, and more than three in 10 oncology practice managers forecasted an increase in white bagging in 2015 compared with 2014.1 Similar to previous study periods, 65.6 percent of cancer drugs are sent from specialty pharmacies directly to patients’ homes for self-administration or home administration, followed by 21.8 percent of drugs delivered directly to oncology practices for treatment of patients (white bagging) and 6.7 percent delivered to patients’ homes for brown bagging.2 A 2015 pharmacy trend report, which includes data from 59 health plans, representing 129.7 million covered individuals, found that 28 percent of medical benefit drug volume was distributed to physician offices by specialty pharmacies through white or brown bagging.3

White and Brown Bagging Create Patient Quality of Care Issues
White and brown bagging create quality of care issues by placing drug management on the patient. At a time when patients with cancer are in active treatment and at their most vulnerable, they are charged with the responsibility of accepting and transporting their own drugs. Community oncologists want this administrative responsibility; are prepared and capable of handling this administration as part of the treatment of patients with cancer; are strongly opposed to shifting the burden of care management to patients; and are gravely concerned that the loss of control in case management is detrimental to patient prognosis. Specialty pharmacies may not have full access to other medical information (e.g., complete medication list, concurrent disease states, comorbidities) needed to perform comprehensive medication reconciliation to assess for interactions and adverse events.4

A part of dispensing cancer drugs is managing patient status. Community oncologists are best suited to provide this support based on their ongoing relationship with the patient. The distance to a specialty pharmacy can be a disadvantage compared with local hospitals or community pharmacies. Adverse events or side effects that could be quickly recognized by an in-person evaluation of the patient may be missed or downplayed in a telephone conversation with the patient, and the opportunity to report the adverse event to a national incident reporting database...
may be lost. Under the current paradigm, practice pharmacies can improve patient safety because the staff has a deep knowledge and understanding of specialty products and the conditions they treat.5

Chemotherapeutic drugs are highly toxic agents, often calibrated to very specific criteria, such as patient weight and current comorbidities, and require very specific storage and handling. The insertion of patients and/or their family members and caregivers, all well-meaning but untrained participants, into the drug distribution chain disrupts the control of the drugs and inserts unknown variables that may affect their efficacy. Product integrity becomes a safety issue for products that require special handling, especially for products that are not designed for self-administration. Lack of temperature control during shipping is one example of how a product's integrity may be compromised by a mail-order model.6

During the course of treatment, adjustments to dosage is common. Often a change is made based on patients’ general status, comorbidities, and the ability to tolerate the treatment. Treatment with drugs dispensed by the practice allows for better patient management through on-the-spot dose changes not possible with white or brown bagging. Patients who require an unexpected dosage change may have to wait to receive treatment until a new order is placed and delivered.7

White and Brown Bagging Create Drug Waste
It is common for the quantity of drugs dispensed by community oncology practices at the beginning of a chemotherapy course of treatment to be limited in anticipation of dosage changes or adverse events. This adjustment is not typically made when drugs are dispensed through white and brown bagging. Any drugs not used because of such a change are wasted. Drugs received for a specific patient cannot be re-dispensed to another patient. For example, if patient A has a drug discontinued, it cannot be provided to patient B and must be wasted.8

Given the high cost of cancer drugs, such waste is expensive and can even be cost prohibitive for the patient and the cancer care delivery system. Despite a portion of white or brown bagged drugs not being used, patients are responsible for the full amount dispensed. White and brown bagging can also lead to excessive waste in instances in which the medication is billed by the pharmacy but is never administered to the patient.9

White and Brown Bagging Create Liability and Responsibility Concerns for Providers
The responsibility for, but inability to fully and properly control, white and brown bagging drugs may cause liability issues for hospitals and physicians. When a drug order is filled through white or brown bagging, the medication leaves the pharmacy and physicians and hospitals have no control over the handling or storage conditions and are unaware of these factors prior to administration. The safety and integrity of the medication is not assured. This raises concerns amongst physicians and hospitals about their liability if an improperly handled medication leads to injury based on factors outside their control. For white bagging, while the provider and institution are not responsible for, or reimbursed for, the mixing of the specialty pharmacy drug, they do assume responsibility for the handling and administration of the drug.10
Summary:

COA opposes white and brown bagging because it interferes with the proper treatment and management of patients with cancer. Both processes can disrupt the chain of control of expensive cancer drugs risking improper storage and can cause delays in the onset of treatment, create waste in such common occurrences as dosage change or the management of adverse events, and places an administrative burden on both patients with cancer and their oncologists. White and brown bagging impact treatment and patient prognosis. The presumed cost savings often do not materialize. Patient continuity of care is ensured by allowing practices to manage all aspects of drug therapy—from initial procurement through dispensing to completion of therapy. This flexibility means patients receive care that is high-quality, high-value, convenient, and personalized. COA strongly opposes white and brown bagging as they are disruptive to the continuity of care and the best possible patient outcomes.

Date:

Approved by the COA Board of Directors on September 16, 2019.

References:

2 Ibid.
4 NCCN Task Force Report: Specialty Pharmacy, Rowena N. Schwartz, PharmD, BCOP; Kirby J. Eng, RPh; Deborah A. Frieze, PharmD, BCOP; Tracy K. Gosselin, RN, MSN, AOCN; Niesha Griffith, MS, RPh, FASHP; Amy Hatfield Seung, PharmD, BCOP; Jennifer M. Hinkel, MSc; Philip E. Johnson, MS, RPh, FASHP; Shirley A. Johnson, RN, MS, MBA; Edward C. Li, PharmD, BCOP; Audrea Hotsko Szabatura, PharmD, BCOP; and Michael K. Wong, MD, PhD, Journal of the National Comprehensive Cancer Network, Vol.8: Issue Supl 4, July 2010.
5 Ibid.
6 Ibid.
8 NCCN Task Force Report, supra note 4.
9 American Society of Hematology supra note 7.
10 American Society of Hematology supra note 7.