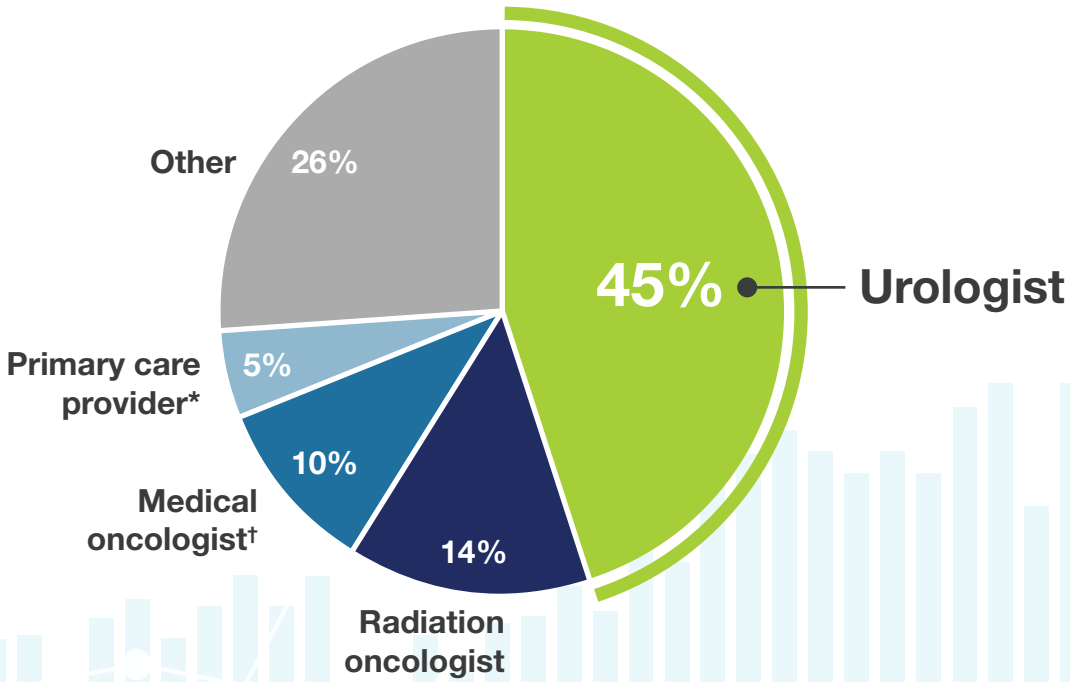
An Analysis of Community Urology Treatment Patterns in Advanced Prostate Cancer

Introduction

Urologists play a key role in the management of prostate cancer. According to a 2010 Surveillance, Epidemiology, and End Results-Medicare analysis of 105,961 patients diagnosed with prostate cancer between 1992 and 2005, urologists accounted for more health services provided to prostate cancer patients across all phases of care than any other specialty (**FIGURE 1**).[1]

FIGURE 1. Prostate cancer health services across all phases of care by provider specialty[1]



*Internal medicine, family practice, and general practice.[1]
†Medical oncology and hematology/oncology.[1]

In partnership with Astellas and Pfizer, PPS Analytics conducted an internal analysis of EHR and practice management system structured data from its proprietary network database comprising more than 100 U.S.-based community urology practices using the PPS Analytics Platform.[2] Practices were segmented by size from nano (5 to 9 providers) to extra large (over 75 providers).*

*Practice selection considerations included: various U.S. regions, practice size, stage of established care guidelines and protocols, and varying proportions of patient disease states.

EHR, electronic health record.

Methodology

Quantitative assessment

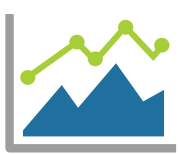
Evaluating treatment pattern consistency with evidence-based guidelines

A quantitative analysis of EHR and practice management system structured data from the PPS Analytics Platform was conducted in 2020 and included health records active in the previous 36 months.[2] All insights were de-identified, and the analysis was conducted in compliance with HIPAA requirements; at no point were third parties, including Astellas and Pfizer, permitted access to protected health information.

The objectives of the analysis were to[2]

1 

Define and identify the number of patients who appeared to be candidates for clinical guideline–recommended therapies stratified by patient type: mCSPC, nmCRPC, and mCRPC.

2 

Quantify the rates at which each patient type received treatments with the highest level of clinical guideline recommendations per the AUA/ASTRO/SUO Guideline for Advanced Prostate Cancer and/or NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Prostate Cancer.

ASTRO, American Society for Radiation Oncology; **AUA,** American Urological Association; **HIPAA,** Health Insurance Portability and Accountability Act; **mCRPC,** metastatic castration-resistant prostate cancer; **mCSPC,** metastatic castration-sensitive prostate cancer; **NCCN®,** National Comprehensive Cancer Network®; **nmCRPC,** nonmetastatic castration-resistant prostate cancer; **SUO,** Society of Urologic Oncology.

Advanced prostate cancer treatment patterns were defined using both descriptive and inferential statistics.[2] Therapies with the highest clinical guidelines recommendations were used as the standard by which to measure variance in care (**TABLE 1**). **Although the analysis assessed adherence to the highest levels of clinical guideline recommendations, it is not possible to gauge the appropriateness of treatment selections. Treatment decisions should be based on independent medical judgment in the context of individual patient characteristics and preferences.**

TABLE 1. Quantitative analysis criteria[2]

	mCSPC	nmCRPC	mCRPC
Clinical state criteria	• Diagnosed with metastatic prostate cancer in the last 36 months • No evidence of castration resistance	• No evidence of metastatic prostate cancer • Identified as castration resistant in the last 36 months • Available PSADT	• Diagnosed with metastatic prostate cancer in the last 36 months • Identified as castration resistant in the last 36 months
Treatments with highest level of clinical guideline recommendations	• ADT + androgen biosynthesis inhibitor • ADT + second-generation androgen receptor inhibitors* • ADT + chemotherapy*	**PSADT > 10 months** • ADT monotherapy **PSADT ≤ 10 months** • ADT + second-generation androgen receptor inhibitors	• ADT + androgen biosynthesis inhibitor • ADT + second-generation androgen receptor inhibitor* • ADT + chemotherapy • ADT + immunotherapy* (bone or nodal metastases only) • ADT + radiopharmaceutical (bone metastases only)
All other treatments	• ADT + fine particle androgen biosynthesis inhibitor • ADT + EBRT • ADT monotherapy • All other treatments	• ADT + secondary hormone therapy† • All other treatments	• ADT + fine particle androgen biosynthesis inhibitor • ADT + secondary hormone therapy† • All other treatments

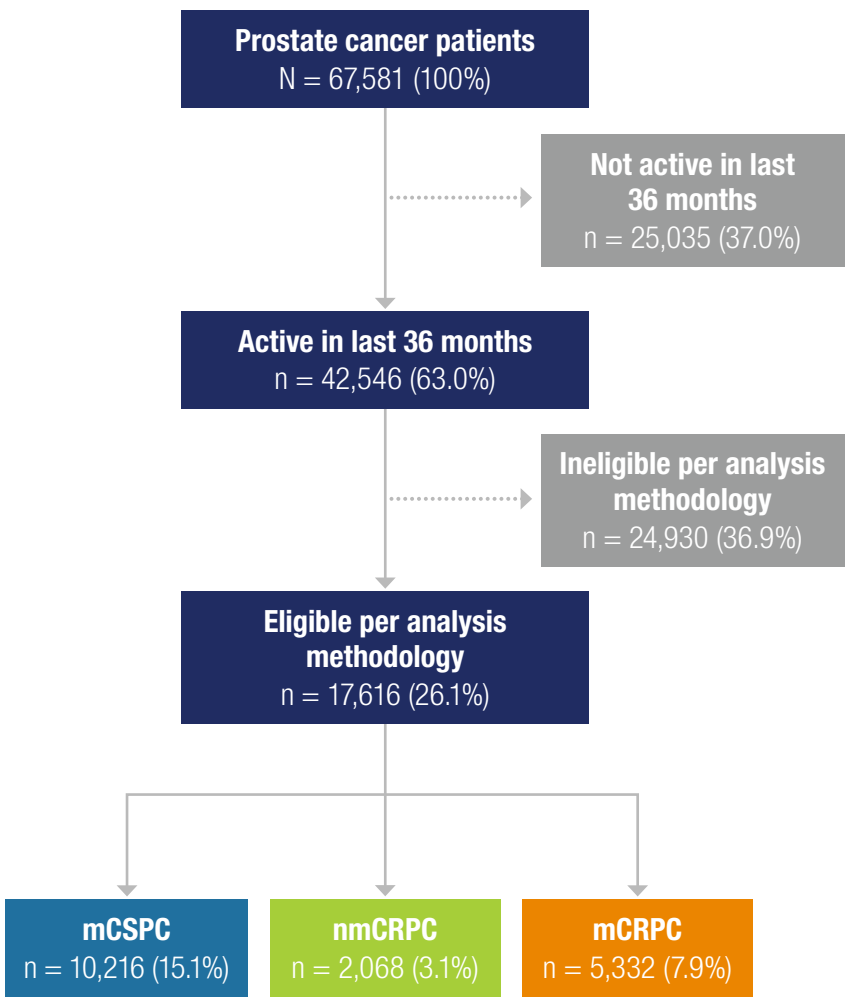
Treatments with highest level of clinical guideline recommendations were those receiving either Category 1 recommendation (NCCN Guidelines®) or Strong Recommendation (AUA/ASTRO/SUO Guidelines) at the time of analysis. A Category 1 recommendation is based on high-level evidence and indicates uniform NCCN consensus that the intervention is appropriate.[3] To view the most recent and complete version of the guideline, go online to NCCN.org. Strong Recommendations are directive statements that an action should (benefits outweigh risks/burdens) or should not (risks/burdens outweigh benefits) be undertaken because net benefit or net harm is substantial.[4] The complete AUA/ASTRO/SUO Guidelines can be found at www.AUAnet.org/Guidelines.

*Only select therapies within this treatment class are recommended in this clinical state. Refer to the full guidelines for specific recommendations.
†Secondary hormone therapy included antifungal therapy, first-generation androgen receptor inhibitor, corticosteroid, and estrogen therapy.[2]

ADT, androgen deprivation therapy; **EBRT,** external beam radiotherapy; **PSADT,** prostate-specific antigen doubling time.

Patient population

FIGURE 2. Flow diagram of patient selection for quantitative analysis[2]



PSA, prostate-specific antigen.

Limitations

The PPS Analytics Platform for prostate cancer is sourced from EHRs from participating community urology practices.[2] The identification of patients for evaluation based on patient type (ie, mCSPC, nmCRPC, and mCRPC) relies on the extensiveness of patient care data documentation. A limitation to such data is that a patient's disease state can be determined in a variety of ways, especially in regards to the identification of castration resistance. While there is a specific International Classification of Disease, 10th Revision (ICD-10) code to formally diagnose a patient with castration resistance, there is not a corresponding code in the preceding 9th Revision.

Variability existed at the practice level in regards to castration resistance diagnosis criteria.[2] Most patients received a castration resistance diagnosis because of 2 consecutive rises in PSA while on ADT (68.5% of patients with nmCRPC; 40.8% of patients with mCRPC). Through qualitative interviews, it was uncovered that some practices used a threshold of greater than 0.0 ng/dL, while others were more conservative and used thresholds of 0.7 ng/dL, 1.0 ng/dL, or 1.5 ng/dL. Because variances in castration resistance diagnosis thresholds cannot be accounted for across all 100 practices in the portal, a PSA rise of greater than 0.0 ng/dL was used in our data model. This means that some of the patients defined as castration resistant in this analysis may not have been recognized as castration resistant at the practice level.

The analysis was limited to member practices of the PPS Analytics network.[2] As such, the results of this analysis may not be representative of all U.S. urology practices.

Qualitative assessment

Identifying possible underlying themes for observed treatment patterns

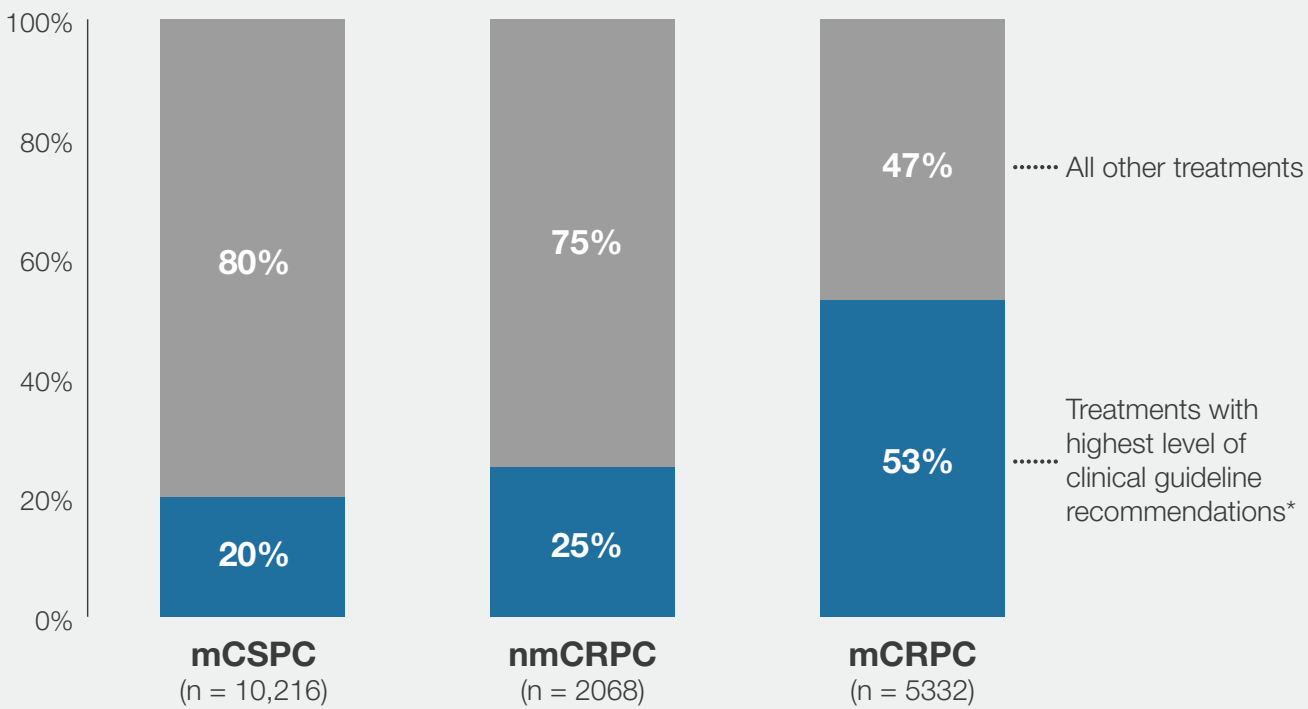
To complement the quantitative analysis, PPS Analytics conducted interviews with clinical navigators, providers, and administrators from 8 urology practices from the PPS network.[2] Interviewed practices were selected to provide a representation of the larger population, varying in practice size and covering multiple geographic practice locations. Although care was taken to ensure the subset aligned with demographics from the quantitative analysis, the small sample size means that it may not be representative of national trends.

Additionally, PPS Analytics conducted chart reviews of 100 de-identified patients at random.[2] The objective of the qualitative assessment was to identify, analyze, and document potential reasons for treatment patterns observed during the quantitative portion of the analysis.

Results

The internal quantitative analysis suggests variation in treatment selection across clinical states[2]

FIGURE 3. Percent of patients receiving treatment by type of clinical guideline recommendation[2]*



Conclusions cannot be made regarding the rationale for why a specific treatment was selected. Treatment decisions should be based on medical judgment in the context of individual patient characteristics and preferences.

*Treatments with highest level of clinical guideline recommendations were those receiving either Category 1 recommendation (NCCN Guidelines) or Strong Recommendation (AUA/ASTRO/SUO Guidelines) at the time of analysis. A Category 1 recommendation is based on high-level evidence and indicates uniform NCCN consensus that the intervention is appropriate.[3] To view the most recent and complete version of the guideline, go online to NCCN.org. Strong Recommendations are directive statements that an action should (benefits outweigh risks/burdens) or should not (risks/burdens outweigh benefits) be undertaken because net benefit or net harm is substantial.[4] The complete AUA/ASTRO/SUO Guidelines can be found at www.AUAnet.org/Guidelines.

The qualitative analysis identified 4 potential operational barriers that may lead to variations in care[2]

Practice representatives comprised clinical navigators, providers, and administrators from 8 urology practices.[2] PPS Analytics conducted a comparative analysis of demographics and treatment patterns from the 8 interviewed practices against the larger quantitative analysis population to ensure appropriate representation.

FIGURE 4. Potential operational barriers to evidence-based care[2]

1 Follow-up appointments

Delays in follow-up care may result in missed opportunities for additional care

2 Protocol adherence

Gaps in protocols directing staff on patient care

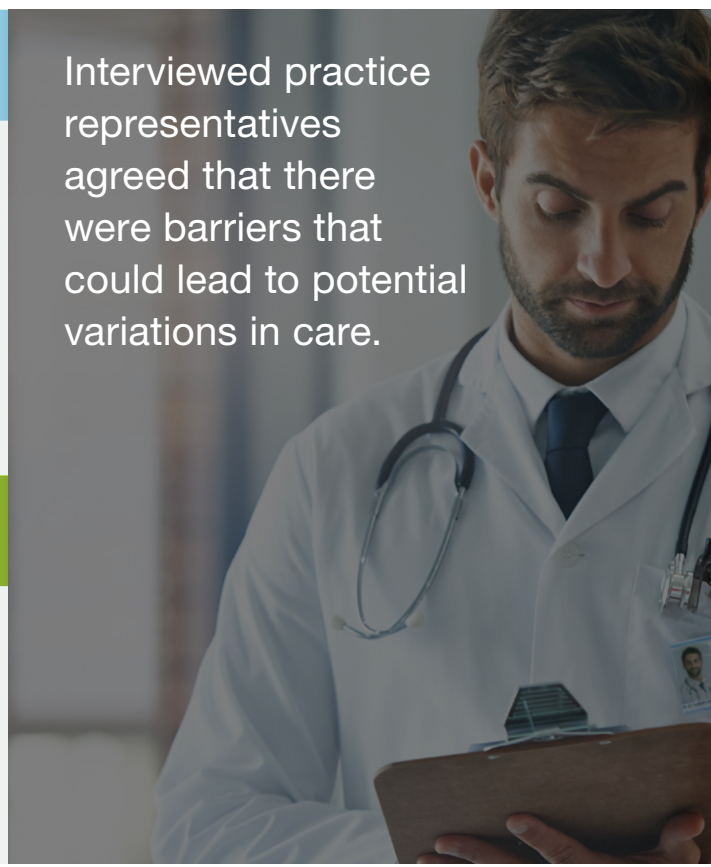
Inconsistent biochemical and radiographic monitoring following LHRH therapy initiation

3 Documentation

Inconsistent workflows and patient care

4 Resource allocation

Inefficient resource allocation (ie, staffing and financial allocations to support protocols/documentation) may diminish patient care



LHRH, luteinizing hormone-releasing hormone.

Sample resources

The following sample resources are not intended to be comprehensive, definitive, or absolute, and have not been validated to demonstrate impact. Your organization is solely responsible for implementing solutions that meet the needs of your organization. While these resources may assist providers, the decision regarding how to treat must ultimately be made by a provider in consultation with the patient.

Sample resources

Click resources to view examples.

1 Follow-up appointments

- Appointment scheduling workflow
- Patient communication guide and example

2 Protocol adherence

- Disease progression and monitoring guides
- Evidence-based treatment guide

3 Documentation

- Patient characteristics guide

4 Resource allocation

- Multidisciplinary care team checklist
- Prior authorization guide

SDOH, social determinants of health.

Available resources RETURN

- Appointment scheduling workflow
- Patient communication considerations and example

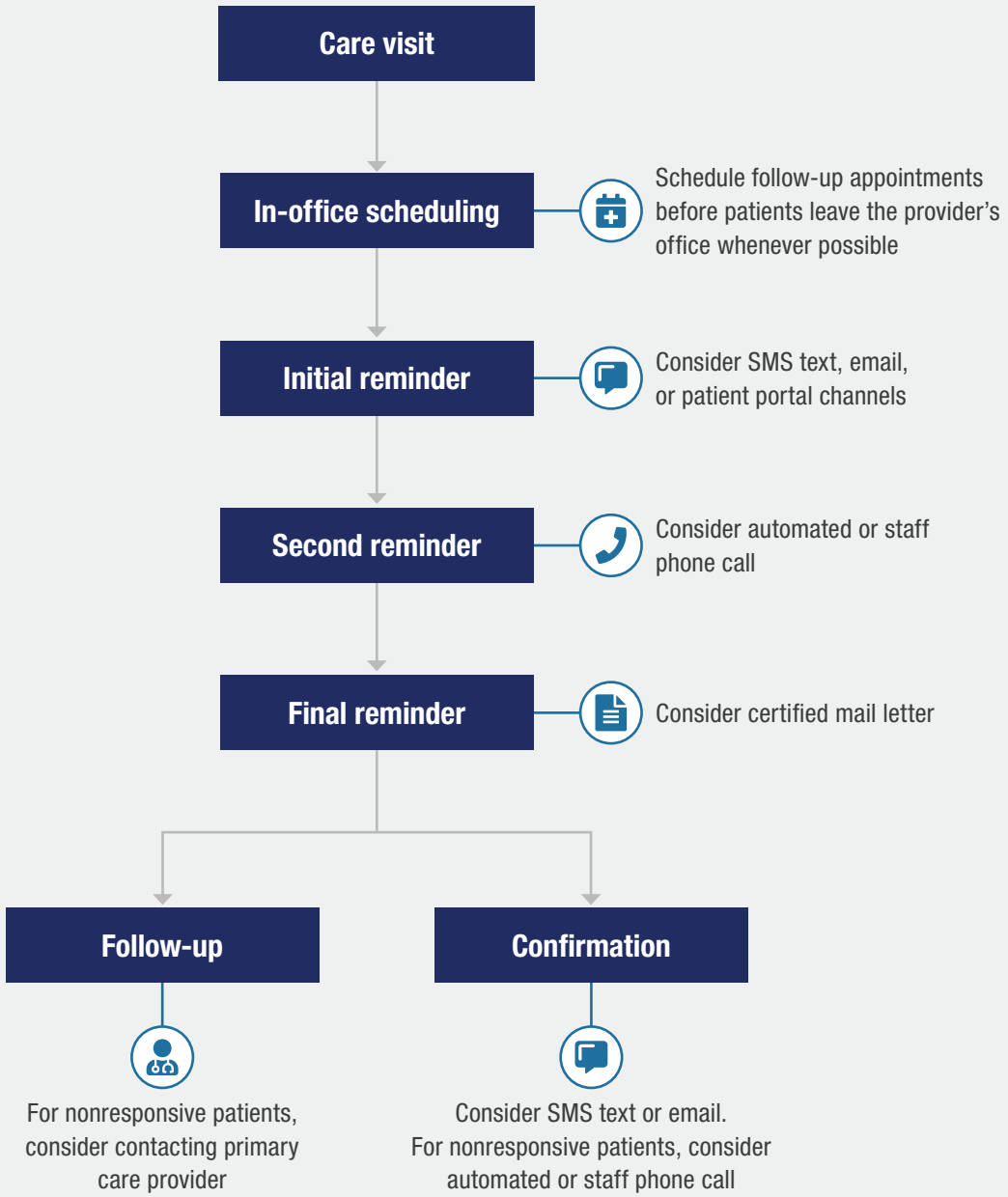
Appointment scheduling workflow

The figure at the right shows an example of an appointment scheduling workflow to help ensure patients have follow-up appointments.

Why it matters

Lack of follow-up appointments may lead to delays in monitoring procedures, identification of progression, and initiation of subsequent treatments.[2]

Example of appointment scheduling workflow



Available resources

RETURN

- Appointment scheduling workflow
- Patient communication considerations and example

Patient communication considerations and example

A variety of channels may be used to facilitate follow-up appointments, including in-office scheduling slips, SMS text, email, secure email via patient portals, automated or live phone calls, and certified letters.

Considerations

Automate patient reminders to standardize follow-up

Tailor the communication channel that meets the needs for both your practice and your patient population

Identify a single champion for consistent patient tracking and communication

Example of patient communication emails

Schedule a follow-up appointment

This is a reminder to schedule your follow-up appointment with [ORGANIZATION; PROVIDER]. Click here or call [XXX-XXX-XXXX] to schedule an appointment.

Appointment confirmation

This is a reminder that you have an appointment scheduled. Please click here to confirm. To reschedule or cancel, click here or call [XXX-XXX-XXXX]. Your appointment details are below:

Date: [DATE]	Provider: [PROVIDER]	Phone: [PHONE]
Time: [TIME]	Location: [ORGANIZATION]	Email: [EMAIL]
	Address: [ADDRESS]	

Examples for illustrative purposes only. It is the responsibility of each practice to develop a template that works for their purposes.

Available resources RETURN

- Disease progression and monitoring guides
- Evidence-based treatment guide

Disease progression and monitoring guides

The recommendations shown at right are based on clinical guidelines and expert consensus. They may aid in standardizing monitoring protocols and identifying patients at the point of progression or who may benefit from additional follow-up.

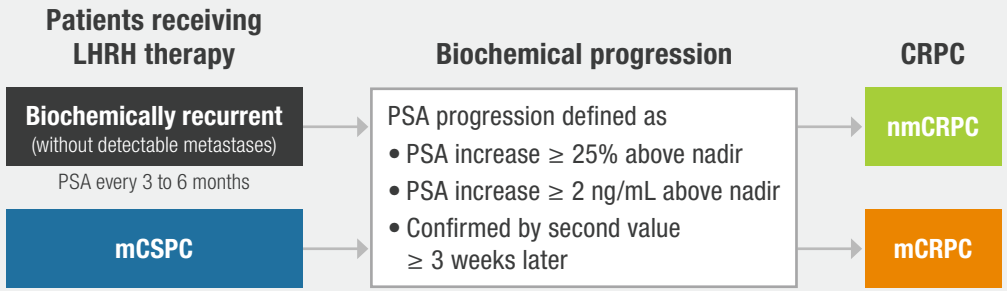
Why it matters

Leading organizations such as the NCCN and AUA recommend routine monitoring of patients with advanced prostate cancer.[3,4] Appropriate monitoring strategies may help ensure patients are considered for recommended treatments based on their stage of prostate cancer.

CRPC, castration-resistant prostate cancer; **PCWG3,** Prostate Cancer Clinical Trials Working Group 3; **RADAR,** Radiographic Assessments for Detection of Advanced Recurrence.

Monitoring for biochemical progression

PSA monitoring recommendations based on NCCN Guidelines and PCWG3[3,5]



Monitoring for metastatic disease

RADAR criteria for conventional imaging based on clinical state and criteria[6]

At diagnosis	Biochemically recurrent	nmCRPC
Intermediate- to high-risk patients with ≥ 2 of the following: • PSA > 10 ng/mL • Gleason score ≥ 7 • Palpable disease (≥ T2b)	PSA: 5-10 ng/mL If negative, rescan at: • PSA = 20 ng/mL • Every PSA doubling thereafter	PSA: ≥ 2 ng/mL If negative, rescan at: • PSA = 5 ng/mL • Every PSA doubling thereafter

Available resources

RETURN

- Disease progression and monitoring guides
- Evidence-based treatment guide

Evidence-based treatment guide

Treatment recommendations stratified by recommendation strength are shown at right.

Why it matters

Prostate cancer treatment recommendations vary by clinical state and evidence levels.[3,4]

Cond, conditional; **CP,** clinical principle; **NA,** not applicable; **Str,** strong.

*Treatment recommendations are provided in context of continued LHRH therapy. Recommendations shown are based on highest level of evidence or strength of recommendation.
†This is a summary of relevant portions of the Guideline. Please see the full AUA/ASTRO/SUO Advanced Prostate Cancer Guideline at www.AUAnet.org/Guidelines.
‡This is a summary of relevant portions of the Guideline. Please see the full NCCN Guidelines for Prostate Cancer at NCCN.org.
§Only select therapies within this treatment class are recommended in this clinical state. Refer to the full guidelines for specific recommendations.
‖Recommendation shown is for docetaxel only.[3,4] Mitoxantrone may be offered as a treatment option for mCRPC (NCCN Guidelines: Category 2A).[3]
¶Includes bilateral orchiectomy or LHRH agonist with or without addition of first-generation antiandrogen or LHRH antagonist.[3]
#AUA: For patients at high risk for developing metastases only (PSA doubling time ≤ 10 months).[4]
**NCCN: In patients with PSA doubling time ≤ 10 months only.[3]
††NCCN: In patients with PSA doubling time > 10 months only.[3]
‡‡AUA: Particularly patients at lower risk (PSA doubling time > 10 months) for developing metastatic disease.[4]
§§May include antifungal, first-generation androgen receptor inhibitor, and corticosteroid therapies.[3]
‖‖Recommendations for adenocarcinoma only.[3]
¶¶In patients with bone metastases only.[3,4]
##In certain asymptomatic/minimally symptomatic patients only.[3,4]

Clinical guideline treatment recommendations by clinical state*[3,4]

Systemic therapy for mCSPC	AUA†	NCCN‡
Androgen biosynthesis inhibitor§	Str (A)	1
Second-generation androgen receptor inhibitor§	Str (A)	1
Chemotherapy‖	Str (A)	1
LHRH monotherapy¶	NA	2A
Fine-particle androgen biosynthesis inhibitor	NA	2B

Systemic therapy for nmCRPC	AUA†	NCCN‡
Second-generation androgen receptor inhibitor#**	Str (A)	1
Observation + LHRH therapy¶††‡‡	CP	2A
Other secondary hormone therapy§§	NA	2A

Systemic therapy for first-line mCRPC	AUA†	NCCN‡‖‖
Androgen biosynthesis inhibitor§	Str (A)	1
Second-generation androgen receptor inhibitor§	Str (A)	1
Radiopharmaceutical§¶¶	Str (B)	1
Chemotherapy‖	Str (B)	1
Immunotherapy§##	Cond (B)	1
Fine-particle androgen biosynthesis inhibitor	NA	2A
Other secondary hormone therapy§§	NA	2A
LHRH monotherapy¶	NA	NA

Available resources RETURN

- Patient characteristics guide

Patient characteristics guide

These patient characteristics may be useful indicators of overall patient state.

Why it matters

Numerous clinical factors, such as PSA kinetics and Gleason score, influence risk of prostate cancer progression.[3] Additionally, nonclinical factors, such as race and geography, play a role in risk of progression and mortality.[3,7,8] Comprehensive documentation of clinical and social characteristics may help contextualize risk and mitigate health inequities by ensuring healthcare providers have holistic information that can help support an individualized treatment approach.

TNM, primary tumor, regional lymph nodes, distant metastasis.

Social determinants of health

Race	According to the American Cancer Society, African American and/or Caribbean descent is a key risk factor for prostate cancer[9]
Zip code	Rural areas and areas with greater degrees of socioeconomic deprivation have been associated with increased prostate cancer mortality rates[8]
Education	Lower levels of education have been associated with lower prostate cancer screening rates[10]
Marital status	Unmarried men have been shown to be at increased risk for prostate cancer–specific mortality compared with married men[11]

Clinical characteristics

Comorbidities	Cardiovascular (eg, hypertension) and endocrine system (eg, diabetes) conditions are commonly reported comorbidities and may be exacerbated by treatments such as LHRH therapy[12,13]
Life expectancy	NCCN Guidelines recommend life expectancy be considered when making prostate cancer treatment and screening decisions[3]
Gleason score	NCCN Guidelines include Gleason scores as a component of risk stratification[3]
Clinical stage (TNM)	NCCN Guidelines include clinical stage as a component of risk stratification[3]
Risk group	NCCN Guidelines recommend stratifying patients by risk group to inform treatment decisions[3]
Genetic/germline mutations	NCCN Guidelines recommend germline genetic testing in select patients based on risk group, ancestry, and family history[3]

Monitoring and disease progression

PSA level	NCCN Guidelines recommend routine PSA testing every 3 to 6 months in patients with advanced prostate cancer[3]
Testosterone level	NCCN Guidelines recommend maintaining castrate serum levels of testosterone (< 50 ng/dL) in patients with CRPC[3]
Bone imaging	Autopsy reports indicate that bone is the most common site of prostate cancer metastasis, occurring in approximately 90% of patients with metastatic prostate cancer[14]
Soft tissue imaging	Although less common than bone metastases, the presence or absence of pelvic ± abdominal or visceral metastases is an important consideration in determining appropriate treatment[3]

Multidisciplinary care team checklist

The checklist to the right includes a list of potential specialties to consider as part of a multidisciplinary prostate cancer team.

Why it matters

Prostate cancer often requires interconnected communication and information transfer across specialties to effectively coordinate optimal care delivery.[15] According to an analysis of treatment selection within a multidisciplinary prostate cancer clinic at MD Anderson (n = 4,451) vs national SEER database trends (n = 392,710), patients receiving multidisciplinary consult were more likely to receive treatment tailored to their risk group.[16] Such an approach is endorsed by the AUA/ASTRO/SUO Advanced Prostate Cancer Guideline.[4]

SEER, Surveillance, Epidemiology, and End Results.

Providers and specialties to consider

- ☐ **Radiation oncologist:** NCCN Guidelines recommend a tailored approach to radiation therapy based on risk group and modality[3]
- ☐ **Medical oncologists** can help determine patient eligibility for advanced prostate cancer treatments such as chemotherapy and immunotherapy[3,17]
- ☐ **Cardiologist:** Cardiovascular conditions such as hypertension and ischemic heart disease are among the most common comorbidities experienced by patients with prostate cancer and may be exacerbated by treatments such as LHRH therapy[12,13]
- ☐ **Primary care provider:** American Cancer Society Prostate Cancer Survivorship Care Guidelines acknowledge that "primary care clinicians should maintain their role as the general medical care coordinator throughout the spectrum of prostate cancer"[18]
- ☐ **Oncology/clinical pharmacists** aid in medication and symptom management as well as supportive care related to specialty medications[19]
- ☐ **Endocrinologist:** Diabetes is present in approximately 11% of patients with prostate cancer and may be exacerbated by treatments such as LHRH therapy[12,13]
- ☐ **Palliative care physician:** NCCN Guidelines recommend the integration of palliative care as part of usual oncology care plans[20]
- ☐ **Psychiatrist/psychologist:** Patients with prostate cancer who receive LHRH therapy are nearly twice as likely to develop depression than those who do not[13]; American Cancer Society Prostate Cancer Survivorship Care Guidelines recommend at least annual assessment of distress, depression, and PSA anxiety in prostate cancer survivors[18]
- ☐ **Diagnostic radiologists** can interpret imaging results and recommend treatment in patients with regional or metastatic prostate cancer[21]
- ☐ **Surgical oncologists/urologists** can help determine patient eligibility for surgery, such as radical prostatectomy[17]
- ☐ **Pathologists** can assess biopsy tissue and assign Gleason scores to help stratify by risk group[3]

Allied professions to consider

- ☐ **Genetic counselor:** NCCN Guidelines recommend pretest genetic counseling in patients receiving genetic testing as well as posttest genetic counseling in patients who test positive for mutations[3]
- ☐ **Oncology nurse navigators** can offer individualized assistance to patients to help coordinate care, overcome healthcare barriers, and provide education[22]
- ☐ **Social workers/counselors** can help patients navigate nonmedical situations such as securing transportation, acquiring home care, and returning to work[23]
- ☐ **Sexual health coach:** Prostate cancer treatments such as radical prostatectomy have been shown to negatively impact sexual function.[3] American Cancer Society Prostate Cancer Survivorship Care Guidelines recommend patients with persistent sexual dysfunction be referred for counseling[18]
- ☐ **Dietitian:** American Cancer Society Prostate Cancer Survivorship Care Guidelines recommend a diet high in vegetables, fruits, vitamin D, and calcium in prostate cancer survivors, especially in those receiving LHRH therapy who are at increased risk for osteoporosis[13,18]

This is not intended to be a comprehensive list and other specialties could also be considered.

Additional support services to consider

ISSUE

The patient does not have a reliable form of transportation and/or experiences long commutes to attend appointments

- Rideshare services offer tailored programs for patients experiencing transportation challenges.[24,25] Such services may be covered in part or in whole by the patient's insurance provider—check with the specific insurer for requirements and restrictions[26]

ISSUE

English is not the patient's primary language

- Coordinate with an affiliated hospital or health system, which may provide translation services to patients with limited English proficiency[27]
- Caregivers, such as spouses and children, may be able to act as de facto translators for patients

ISSUE

The patient has a difficult time understanding their condition and/or medical care plan

- According to the 2003 National Assessment of Adult Literacy, 36% of Americans possess basic or below basic health literacy[28]
- The Agency for Healthcare Research and Quality offers a Health Literacy Universal Precautions Toolkit to help facilitate effective communications between providers and patients[29]

Available resources

- Multidisciplinary care team checklist
- Additional support services to consider
- Prior authorization guide

Prior authorization guide

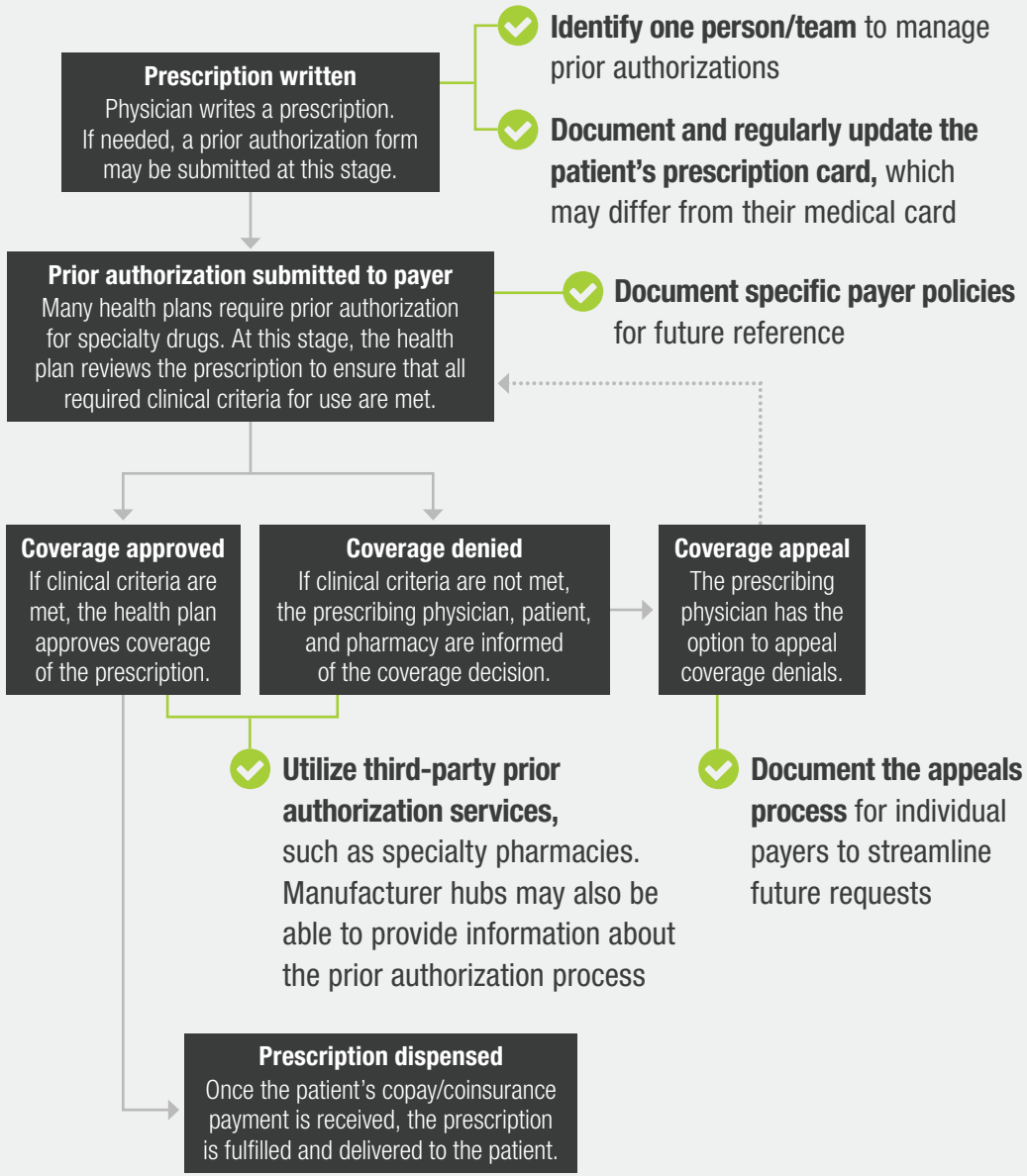
Consider this resource when submitting prior authorization requests for prostate cancer medications to help ensure timely and efficient resolution of coverage determinations.

Why it matters

A 2020 American Medical Association physician survey (n = 1,000) found that prior authorization requirements result in care delays 94% of the time.[30] In the same survey, 79% of physicians noted that prior authorization requirements lead to treatment abandonment at least "sometimes." Efficient handling of prior authorization requests may help mitigate delays in initiating or abandoning patient therapy.

EXAMPLE PRIOR AUTHORIZATION FORM CHECKLIST

General tips for advanced prostate cancer prior authorizations



Prior authorization processes and criteria vary by plan. Check with the plan sponsor for specific requirements.

RETURN

Available resources

- Multidisciplinary care team checklist
- Additional support services to consider
- Prior authorization guide

Prior authorization guide

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EXAMPLE PRIOR AUTHORIZATION FORM CHECKLIST

Key information typically requested by payers for prior authorizations

Prior authorization processes and criteria vary by plan. Check with the plan sponsor for specific requirements.

Patient demographics

- ☐ Name
- ☐ Date of birth
- ☐ Address
- ☐ Phone number

Patient diagnosis information

- ☐ Primary diagnosis code
- ☐ Secondary diagnosis code
- ☐ Diagnosis date
- ☐ PSA values
- ☐ Imaging results
- ☐ Testosterone values
- ☐ Pathology reports

Provider information

- ☐ Office name
- ☐ Office address
- ☐ Office phone number
- ☐ Provider name
- ☐ Provider NPI number

Medication information

- ☐ Name
- ☐ New or refill

Medication information (cont'd)

- ☐ Strength
- ☐ Dosage and administration
- ☐ Quantity
- ☐ Number of refills
- ☐ Drug allergies

Prescription insurance information

- ☐ Insurer name
- ☐ Insurer address
- ☐ Insurer phone number
- ☐ RxBIN #
- ☐ RxPCN #
- ☐ RxGroup #
- ☐ Member ID #

Previous medications

- ☐ Name
- ☐ Dosage and administration
- ☐ Duration of therapy
- ☐ Reason for discontinuation

Clinical rationale

- ☐ Clinical criteria and evidence (eg, clinical guideline recommendations) to demonstrate appropriate use

NPI, National Provider Identifier.

Examining community urology practice trends in advanced prostate cancer

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