

Multidisciplinary Care Model Rationale for Building Your Team

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Disclosures

- Data Safety Monitoring Committee Member-SABRE Study, Boston Scientific
- Immediate Past Chair and Member, NCCN Guidelines Panel-Early Detection of Prostate Cancer



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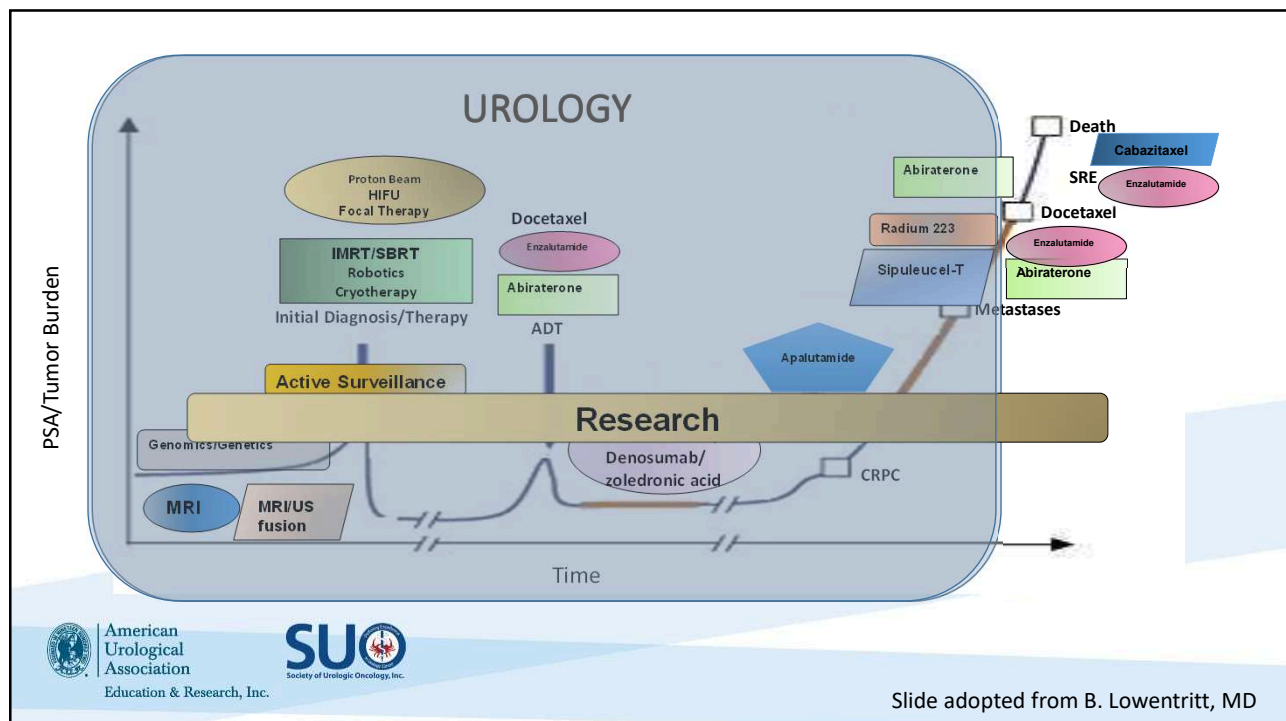
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Objectives

- Understand the clinical guidelines for states of advanced prostate cancer (APC)
- Discuss the rationale for the Urologist who cares for patients with APC
- Develop a framework for multidisciplinary care of APC patients based on AUA-SUO guidelines



Clinical States of Advanced Prostate Cancer

- BCR- biochemical recurrence
- mHSPC- metastatic hormone sensitive prostate cancer
- nmCRPC- non-metastatic castration resistant prostate cancer
- mCRPC- metastatic castration resistant prostate cancer



AUA/ASTRO/SUO Advanced Prostate Cancer Algorithm

BIOCHEMICAL RECURRENCE WITHOUT METASTATIC DISEASE

Clinicians should use **PSMA PET imaging preferably**, where available, in patients with PSA recurrence. (Expert Opinion)

Prognosis

Clinicians **SHOULD**
Inform patients regarding the risk of developing metastatic disease and follow patients with serial PSA measurements and clinical evaluation

Perform periodic staging evaluations consisting of cross sectional imaging (CT, MRI) and technetium bone scan in patients who are at higher risk for development of metastases

Clinicians **MAY**

Utilize novel PET-CT scans as an alternative to or in the setting of negative conventional imaging

Consider radiographic assessments based on overall PSA and PSA kinetics

Treatment

Clinicians **SHOULD**
Offer observation or clinical trial enrollment

Clinicians **SHOULD NOT**
Routinely initiate ADT

Clinicians **MAY**
Offer intermittent ADT in lieu of continuous ADT if ADT is initiated in the absence of metastatic disease



AUA/ASTRO/SUO Advanced Prostate Cancer Algorithm

METASTATIC HORMONE SENSITIVE PROSTATE CANCER

In selected patients with de novo mHSPC, clinicians should offer **ADT in combination with docetaxel and either abiraterone acetate plus prednisone or darolutamide.** (Strong Recommendation; Evidence Level: Grade A)

Prognosis

Clinicians SHOULD

Assess the extent of metastatic disease (bone, lymph node and visceral metastasis) ~~using conventional imaging~~

Assess the extent of metastatic disease (high versus low volume)

Assess if the patient is experiencing symptoms from metastatic disease

Obtain a baseline PSA and serial PSAs at a minimum of three to six month intervals after initiation of ADT and consider periodic conventional imaging

Offer genetic counseling and germline testing regardless of age and family history

Treatment

Clinicians SHOULD

Offer ADT with either LHRH agonists or antagonists or surgical castration

Offer ~~continued~~ ADT in combination with either androgen pathway directed therapy (abiraterone acetate plus prednisone, apalutamide, enzalutamide or chemotherapy (docetaxel))

Clinicians MAY

Offer primary radiotherapy to the prostate in combination with ADT in selected patients with low-volume metastatic disease

Clinicians SHOULD NOT

Offer first generation antiandrogens in combination with LHRH agonists, except to block testosterone flare

Offer oral androgen pathway directed therapy without ADT

Recent publication of **ENZAMET, PEACE-1** and **ARASENS** trials provide newer paradigms in this space



AUA/ASTRO/SUO Advanced Prostate Cancer Algorithm

NON-METASTATIC CASTRATION RESISTANT PROSTATE CANCER

Prognosis

Clinicians SHOULD

Obtain serial PSA measurements at three to six month intervals and calculate PSA doubling time starting at time of development of castration-resistance

Assess for development of metastatic disease using conventional imaging at intervals of six to twelve months

Treatment

Clinicians SHOULD

Offer apalutamide, darolutamide, or enzalutamide with continued ADT to patients at high risk for developing metastatic disease

Clinicians MAY

Recommend observation with continued ADT, particularly for those at lower risk for developing metastatic disease

Clinicians SHOULD NOT

Offer systemic chemotherapy or immunotherapy outside the context of a clinical trial



AUA/ASTRO/SUO Advanced Prostate Cancer Algorithm

METASTATIC CASTRATION RESISTANT PROSTATE CANCER

Clinicians should assess nmCRPC patients for development of metastatic disease using **conventional or PSMA PET imaging at intervals of 6 to 12 months.** (Expert Opinion)

<p>Prognosis</p> <p>Clinicians SHOULD Obtain baseline labs and review location of metastatic disease, disease-related symptoms, and performance status</p> <p style="background-color: #00aaff; color: white; text-align: center; padding: 2px;">[Redacted]</p> <p>Offer germline and somatic tumor genetic testing</p> <p>Treatment</p> <p>Clinicians SHOULD Offer continued ADT with abiraterone acetate plus prednisone, docetaxel, or enzalutamide</p> <p>Consider prior treatment in sequencing agents and recommend therapy with an alternative mechanism of action</p> <p>Offer radium-223 to patients with symptoms from bony metastases from mCRPC and without known visceral disease or lymphadenopathy >3cm</p>	<p>Treatment (cont.)</p> <p>Clinicians SHOULD (cont.) Recommend cabazitaxel rather than an alternative androgen pathway directed therapy in patients who received prior docetaxel and abiraterone acetate plus prednisone or enzalutamide</p> <p>Offer a PARP inhibitor to patients with deleterious or suspected deleterious germline or somatic HRR gene-mutated mCRPC following prior treatment with enzalutamide or abiraterone, and/or a taxane-based chemotherapy</p> <p>Offer pembrolizumab to patients with mismatch repair deficient or microsatellite instability high CRPC</p> <p>Clinicians MAY Offer sipuleucel-T to asymptomatic/minimally symptomatic patients</p> <p>Offer cabazitaxel to patients who received prior docetaxel with or without prior abiraterone acetate plus prednisone or enzalutamide</p> <p>Offer platinum-based chemotherapy to patients with deleterious or suspected deleterious germline or somatic HRR gene-mutated mCRPC following prior treatment with enzalutamide or abiraterone acetate, and/or a taxane-based chemotherapy who cannot use/obtain a PARP inhibitor</p>
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Clinicians should consider offering **Lutetium-617** to patients with progressive mCRPC having previously received docetaxel and androgen pathway inhibitor with a positive PSMA PET imaging study. (Strong Recommendation; Evidence Level Grade: A)

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THE UROLOGIST'S ROLE IN LEADING A MULTIDISCIPLINARY APC CLINIC

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Goals of the MDC

- Simplify the treatment decision-making process for the patient by including the entire team in one place
 - “One Stop Shop”
- Deliver high quality care through collaborative discussion with Medical Oncology, Radiation Oncology, Physician Extenders, Patient Navigator, Specialty Pharmacy, and Patient/Family
- Provide consistency with a team approach
- Encourage participation in clinical trials
- Improve patient satisfaction and potentially impact overall survival



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Rationale for the Urologist

- Most patients diagnosed with prostate cancer have encountered a Urologist
 - Biopsy
 - +/- Surgery
 - PSA follow-up
 - Post-treatment complications
- Understand the natural progression of disease and management through the various disease states
- Patients express the desire for continuity of care, even if there is disease progression
- Can manage outlet obstruction, upper tract obstruction, hematuria, etc.



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Multidisciplinary care for patients with HCC: a systematic review and meta-analysis

Karim Seif El Dahan¹ | Annika Reczek¹ | Darine Daher¹ | Nicole E. Rich¹ | Ju Dong Yang² | David Hsiehchen¹ | Hao Zhu¹ | Madhukar S. Patel³ | Maria del Pilar Bayona Molano⁴ | Nina Sanford⁵ | Purva Gopal⁶ | Neehar D. Parikh⁷ | Adam C. Yopp³ | Amit G. Singal¹

Hepatology Commun 2023

Does Multidisciplinary Team Management Improve Clinical Outcomes in NSCLC? A Systematic Review With Meta-Analysis

Gilberto de Castro Jr., MD, PhD,^{a,*} Fabiano Hahn Souza, MD, PhD,^b Júlia Lima, MSc,^b Luis Pedro Bernardi, BBS,^b Carlos Henrique Andrade Teixeira, MD,^c Gustavo Faibischew Prado, MD, PhD^c; Grupo Brasileiro de Oncologia Torácica (GBOT)

The Impact of the Multidisciplinary Tumor Board on Head and Neck Cancer Outcomes

JTO Clin Res Rep 2023

Jeffrey C. Liu, MD; Adam Kaplon, BA | Elizabeth Blackman, MPH; Curtis Miyamoto, MD; Deric Savior, MD; Camille Ragin, PhD



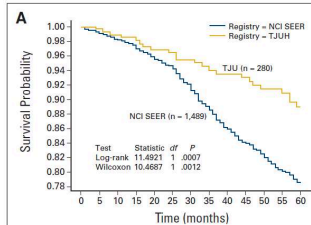
Laryngoscope 2020

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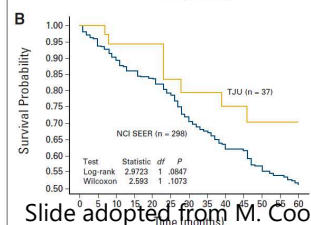
An MDC May Improve Survival in APC

Enhancing Prostate Cancer Care Through the Multidisciplinary Clinic Approach: A 15-Year Experience

- Weekly clinic started at Jefferson in 1996
- Urology, radiation oncology, medical oncology, medical genetics, pathology, radiology, clinical trial and social work
- Newly diagnosed and recurrent prostate cancer patients



T3



T4



Gomella et al, J Oncol Pract 2010

Slide adopted from M. Cookson, MD, MMHC

Where Do You Get Patients?

- Internal referral (Particularly in larger group practices)
- Manual chart review
 - MD or APP
- EMR inquiries
- Data analytics software
 - PSA and imaging information
 - Adherence to pathways
 - Initiation of ADT
 - Eligibility for advanced treatment or clinical trials

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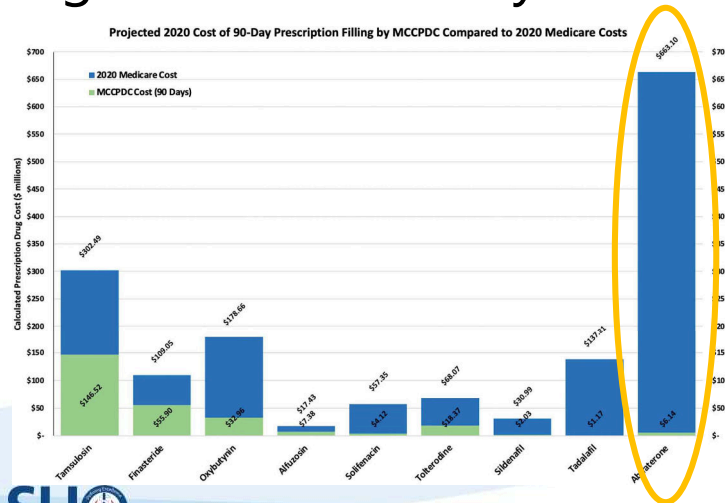
Expertise and Partnerships

- Familiarity with clinical guidelines and advances in therapy
- Act as resource for APPs and partners
- **APP responsibilities/opportunities**
 - Clinical guidelines and expertise through experience
 - Communicate with MD partner, particularly if at a different site
- Specialty pharmacy
 - Assist with drug-drug interactions
 - Communicate with Foundation funders and company-specific programs to lower cost

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Mitigating Financial Toxicity



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What Therapies Can Urologists Provide

- Injectable or oral ADT
- Second line oral therapies
 - Enzalutamide
 - Abiraterone acetate
 - Darolutamide
 - Apalutamide
- Immunotherapy (sipuleucel-T)
- PARPi/Docetaxel (Medical Oncology)
- Surgical castration



Integrated Pharmacy Model



Shared electronic medical record (EMR) allows effective communication regarding:

- Treatment access and initiation
- Adherence and side effect monitoring
- Medication reconciliation
- Changes to treatment or treatment discontinuation

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Cost Mitigation Options

Medication	Commercial insurance	Government insurance (CMS)	Uninsured
Abiraterone 250mg and 500mg	Some manufacturers have copay cards	Look for foundation assistance Max OoP is \$2100/year	Use GoodRx or Mark Cuban Cost Plus drugs (\$70 for #120)
Abirtega* (abiraterone) 250mg	No copay card available	Non-preferred	Can purchase for \$177 at certain SPs (LDD)**
Erleada (apalutamide) 60mg and 240mg	Manufacturer copay card available (patient pays \$0)	Look for foundation assistance Max OoP is \$2100/year Also, PAP eligible	Refer to manufacturer for PAP Samples available
Akeega (niraparib/abiraterone 100mg/500mg and 50mg/500mg)	Manufacturer copay card available (patient pays \$0)	Look for foundation assistance Max OoP is \$2100/year Also, PAP eligible	Refer to manufacturer for PAP Samples available
Xtandi (enzalutamide) 40mg and 80mg	Manufacturer copay card available (patient pays \$0) Max benefit of \$7k/year	Look for foundation assistance Max OoP is \$2100/year Also, PAP eligible	Refer to manufacturer for PAP Samples available
Nubeqa (darolutamide) 300mg	Manufacturer copay card available (patient pays \$0) Max benefit of \$25k/year	Look for foundation assistance Max OoP is \$2100/year Also, PAP eligible	Refer to manufacturer for PAP Samples available
Orgovyx (relugolix) 120mg	Manufacturer copay card available (patient pays \$10) Max benefit of \$10k/year	Look for foundation assistance Max OoP is \$2100/year Also, PAP eligible	Refer to manufacturer for PAP Samples available

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501(c)(3) Charitable Foundations for Copay Support (primarily patients with CMS coverage)

PAN Foundation

Prostate cancer - Copay

CancerCare Co-Payment Assistance Foundation

Prostate Cancer - Copay

HealthWell Foundation

Prostate Cancer - Medicare Access - Copay

Patient Advocate Foundation Co-Pay Relief

Prostate Cancer - Copay

Patient Advocate Foundation Co-Pay Relief

Prostate Cancer Health Equity Fund - Copay

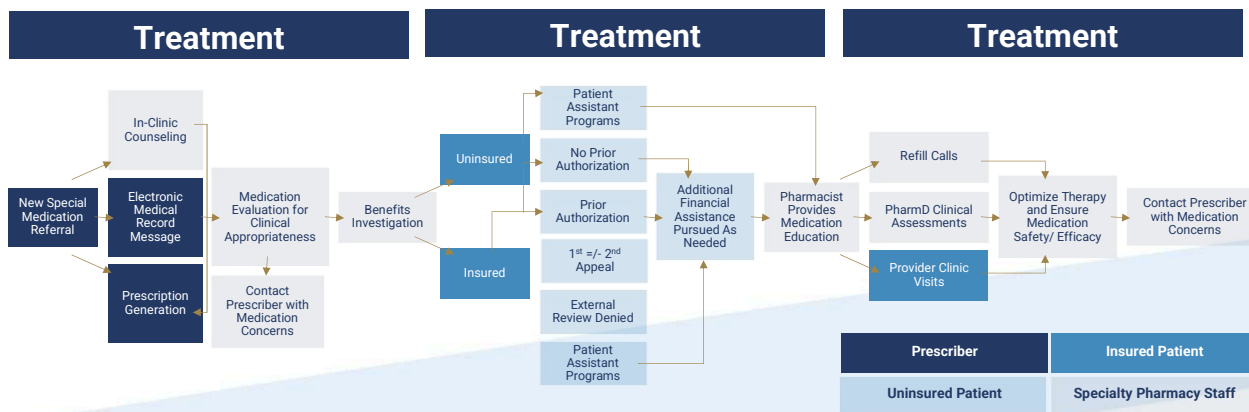
The Assistance Fund

Prostate Cancer - Copay



Courtesy of Carson Lamb, PharmD, CSP
Clinical Pharmacist
Vanderbilt Specialty Pharmacy

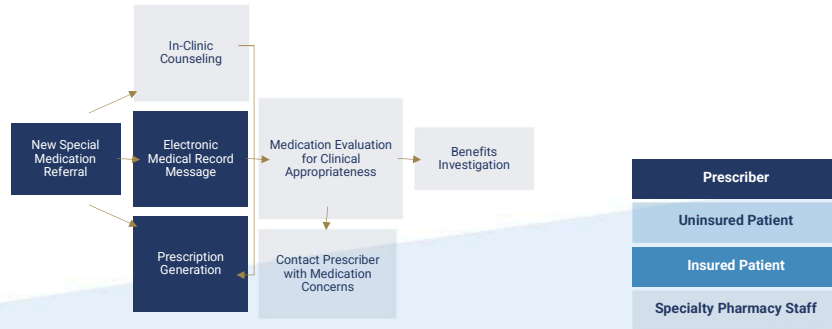
VSP Workflow Process



Courtesy of Keri Wyatt, PharmD, CSP
Program Director, Trade Relations and Market Access
Vanderbilt Specialty Pharmacy Services

VSP Workflow Process

Treatment Evaluation

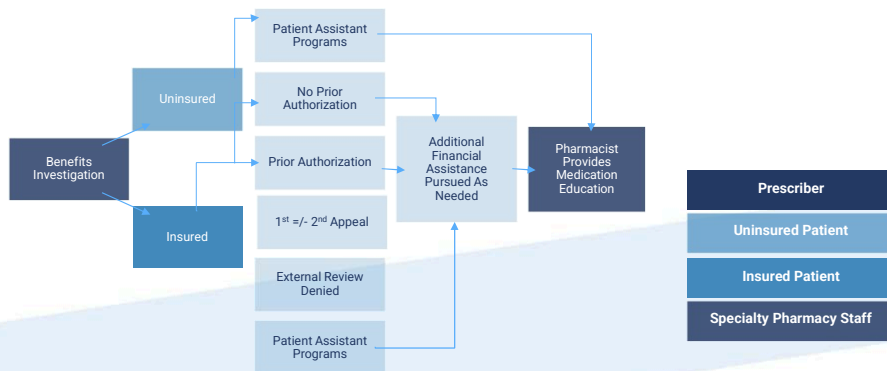


Courtesy of Keri Wyatt, PharmD, CSP
Program Director, Trade Relations and Market Access
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VSP Workflow Process

Treatment Access



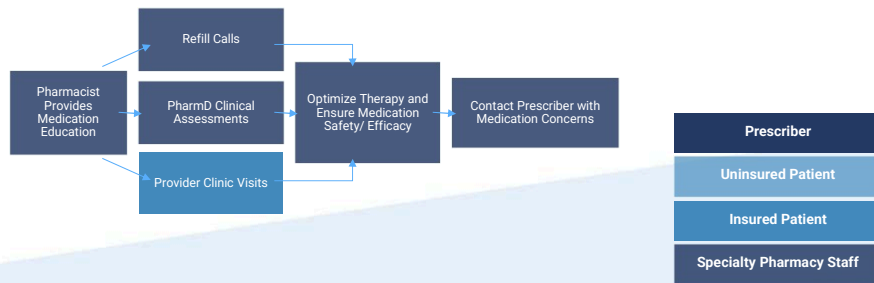
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VSP Workflow Process

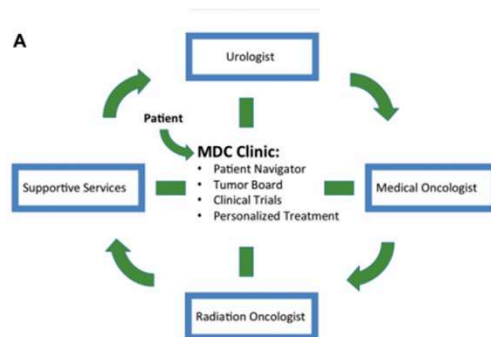
Treatment Monitoring



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Models for a Successful MDC

- Medical Oncology/Radiation Oncology
 - Weekly Tumor Board
- Nuclear Medicine
- Specialty Pharmacy
 - Payment assistance, oral medications mailed
- Medical Genetics
 - Counseling and germline/somatic testing
- Apheresis Location
 - For sipuleucel-T (American Red Cross)
- Palliative Care/Hospice
- Industry Partners (Clinical Trials)



- Virtual MDC Models
1. Same day/different clinic
 2. Different day/different clinic

Is an APC Clinic Solely the Purview of an Academic Center?

- Absolutely NOT!!
- In fact, many LUGPA groups have championed MDC as part of an integrated care model
- Several community practitioners are leaders in clinical trial design and implementation
- Larger urology groups more likely have sufficient facilities and staff to incorporate MDCs in their practice without needing to hire additional personnel



LUGPA
Integrated Practices
Comprehensive Care



Slide adopted from M. Cookson, MD, MMHC

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Summary

- Patients with advanced prostate cancer have several options for treatment that can be managed by a Urologist
- A successful multidisciplinary clinic provides the best opportunity for patients to achieve balance in management
- AUA/SUO/ASTRO Advanced Prostate Cancer Guidelines are designed to aid the clinician and assist in the MDC Model delivery
- Don't forget clinical trials!



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Thank You!

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