THE CANCER LETTER

PO Box 9905 Washington DC 20016 Telephone 202-362-1809

Vol. 31 No. 5
Feb. 4, 2005

Price $335 Per Year

CMS Develops New Math of Medicare: Reimbursement Money For Outcomes Data

By Paul Goldberg

In two separate decisions last week, Medicare officials established that the federal program would pay for pricey new cancer drugs and diagnostic services, but only in the context of generating data on outcomes.

The two "National Coverage Determinations" released on Jan. 28 provide reimbursement for four new colorectal cancer drugs used in nine NCI-sponsored trials and offered payment for PET scanning for cancer diagnosis for patients who participate in clinical studies or submit information to a database that's being designed by the agency.

CMS officials said the decisions were part of the agency's effort

(Continued to page 2)

NIH Policy:

NIH Bans Consulting For Biomedical Firms, Restricts Stock Ownership And Awards

By Kirsten Boyd Goldberg

NIH announced a sweeping overhaul of its ethics regulations, prohibiting employees from taking side jobs as consultants for drug and health care companies, owning stock in medical-related companies, and receiving gifts or awards over $200.

The new rules are intended to remove conflicts of interest, and the appearance of conflicts, NIH Director Elias Zerhouni said.

"We believe that we need to hold NIH and ourselves as scientists at NIH to a higher standard, because we do have national, public-health responsibilities," Zerhouni said at a news conference Feb. 1 where he announced the policy changes.

Over the past year, NIH has been hit with revelations that scientists and administrators received substantial income from consulting or from awards, in arrangements that raised questions of conflicts. In many cases, the employees failed to properly report the income.

Zerhouni initially resisted an across-the-board ban on industry consultation, arguing that these collaborations are necessary for faster translation of science into medical applications (**The Cancer Letter**, June 25, 2004).

"I've changed my mind," Zerhouni said earlier this week. "I'm not confident that we can continue to pretend that we have a system that works."

Zerhouni said that a series of stories published in the Los Angeles Times

(Continued to page 5)

Medicare Will Pay For Drugs In Nine NCI-Sponsored Trials

(Continued from page 1)

to devise methodology for tying reimbursement to monitoring of outcomes. "We are dipping our feet into the water, as it were, in this particular issue of requiring data collection as a condition of coverage," said Steve Phurrough, director of the Coverage and Analysis Group of the CMS Office of Clinical Standards and Quality.

The agency's goal is to devise a transparent policy that would apply broadly to reimbursement of cancer care and across other areas of medicine, Phurrough said. To solicit advice on linking assessment of outcomes to reimbursement, will conduct an open forum Feb. 14, and would draft a guidance document by the end of March.

"I don't think it's going to be in its first rendition the final word," Phurrough said, describing the guidance document. "I suspect there are going to be some changes as we move forward, once we figure out better how to do this and what works and doesn't work."

The agency last year largely pacified oncologists by giving them an opportunity to charge additional fees in exchange for submitting data on side effects of chemotherapy. CMS created the one-year "demonstration project" as it switched from the reimbursement system that underpaid oncologists for their services, but allowed them to make money on the drugs they infused. It is unclear whether the data submitted to CMS through the project would have scientific value. However, it established the pattern where collection of outcomes data in cancer leads to additional reimbursement (**The Cancer Letter**, Nov. 5, 2004).

The CMS decision on colorectal cancer drugs is the most important of the two actions announced last week. Initiated two years ago, the coverage decision applies to the expensive new generation of colorectal cancer drugs—Captosar (irinotecan), Eloxatin (oxaliplatin), Erbitux (cetuximab), and Avastin (bevacizumab).

By deciding to mandate coverage of the four drugs in nine NCI-sponsored trials, the agency instructed its contractors to pay for the FDA-approved drugs used either on the control arms or on the experimental arms of the phase I through phase III trials. The agency is obligated to reimburse routine medical care for patients involved in clinical trials. Also, contractors often reimburse the cost of drugs, and, in many cases, the drugs are provided by the sponsors.

CMS refrained from modifying the existing requirement for coverage of the four colorectal cancer drugs, relying on the FDA-approved indications as well as uses listed in recognized compendia. Also, no changes were made in "coverage for any off-label uses of these drugs provided outside of the clinical trials identified in this decision memorandum." Medicare contractors remain free to decide on "medically accepted uses of off-label indications," the document states.

The decision memorandum is posted at www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=90. Materials related to the Feb. 14 meeting are posted at www.cms.hhs.gov/providers/cti/.

Initially, the colorectal cancer NCD caused great consternation in oncology (**The Cancer Letter**, March 21, 2003). A determination that explicitly restricts coverage would have precluded Medicare contractors from paying for off-label use of this new generation of drugs. Did the agency envision a role that went beyond simply paying for drugs used in accordance with the FDA label or information contained in the compendia?

Last week, CMS demonstrated that rather than trying to skimp on payment, it was contemplating the difficult—some may say quixotic—role of inducing pharmaceutical companies and oncologists to produce data relevant to reimbursement decisions and monitoring outcomes of cancer treatments.

Reading between the lines of the colorectal cancer decision memorandum, clinical researchers may see the potential of obtaining reimbursement for a clinical trial for an indication that a pharmaceutical company would

THE CANCER LETTER

Member, Newsletter and Electronic Publishers Association

Editor & Publisher: Kirsten Boyd Goldberg
Editor: Paul Goldberg
Editorial Assistant: Shelley Whitmore Wolfe

Editorial: 202-362-1809 Fax: 202-318-4030
PO Box 9905, Washington DC 20016
Letters to the Editor may be sent to the above address.

Customer Service: 800-513-7042
PO Box 40724, Nashville TN 37204-0724
Customer service FAQ: www.cancerletter.com

Subscription $335 per year worldwide. ISSN 0096-3917. Published 46 times a year by The Cancer Letter Inc.
Founded Dec. 21, 1973, by Jerry D. Boyd.

consider a money-loser or for a comparative trial that sponsors may regard as too risky.

"We have heard over and over again from various academic centers and people who run trials that there are companies, who—once they have a good market share for their drug—are not providing the drug free in trials," said CMS official Phurrough. "What we did in this particular decision—recognizing that it's limited—is say to contractors, 'In these trials, pay for these drugs and other clinical costs.'"

Reading the same decision document, a pharmaceutical company may see a different set of incentives: the opportunity to develop clinical potential of drugs without having to provide expensive drugs to researchers at no cost. Also, institutes beyond NCI would likely be equally interested in this prospect.

It is unclear whether similar coverage would be extended for other government-sponsored trials and pharmaceutical company studies, CMS officials say.

"What we would like to do now is to step back a minute, convene some open-door forums and some expert panels, and discuss the issue of what's the process we are going to use to determine those coverage decisions—whether they are on drugs or devices or procedures—where we are going to require some kind of data collection," Phurrough said. "There is a potential to do that expansion to other kinds of trials, if they are not already covered under our other trial policies, but we will want to define that process a bit more clearly, and not do it on an ad hoc basis, as we have done thus far."

Since colorectal cancer is relatively common, and since it used to be treated with an old, relatively inexpensive drug, 5-fluorouracil, stakes are enormous. The U.S. healthcare system—largely Medicare—is likely to pay billions of dollars for this new generation of drugs (**The Cancer Letter**, March 5, 2004).

Considering that the oncology profession hadn't succeeded at defining the optimal 5-FU regimen over four decades of its use, optimizing the regimens containing four new drugs would be an immense task that would require many clinical trials.

"Our role is to stimulate the collection of data that would be useful to providers and patients in deciding what the best treatments are," Phurrough said. "It is difficult in colorectal cancer, where time lines are short, to do all of the randomized trials that should be done to get good, clear labeled indications, which is why you have a lot off-label use. We think, particularly in the field of cancer therapy, that data collection is important, and we want to assist the medical community and industry in coming up with the best ways to do that."

Collection of data would have to be greatly expanded, Phurrough said. "We've met with the whole host of individuals—oncologists—whom we tend to agree with that seem to think that there shouldn't be a cancer patient getting anticancer therapy that doesn't have the data submitted to some kind of a system that looks at outcomes on that particular patient," he said.

Data collection doesn't have to be limited to clinical trials, Phurrough said. "There are various means of collecting data that give you various levels of information, and we think you can enroll patients into one or more than one of those particular systems, some of which are more rigorous than others, to answer different questions," he said. "There are some questions that need very rigorous trials, and there are some questions that need less rigorous trials. What we want to encourage the conversation around is how do you determine which questions need which kind of data collection so we have the simplest data collection systems that will answer the questions that are being asked."

It's possible that CMS would have to ask Congress to change reimbursement laws to motivate drug companies to conduct additional trials, Phurrough said.

"Congress tells us to pay for any labeled indication for cancer drugs and any off-label indication that's in the compendia," he said. "Those are Congressional laws. As we have this open conversation with the public, the smart people may recommend that some of those indications need data collection. There is no incentive to collect data in those instances because we are going to pay for it anyway."

The CMS decision extends coverage to phase I through III trials sponsored by NCI. The list of these trials follows:

• **Study 6660.** Phase I will determine MTD and DLT evaluating the use of bevacizumab in carcinoma of the GI tract, breast, and ovary. It compares the use of capecitabine, irinotecan and bevacizumab; with capecitabine, oxaliplatin and bevacizumab.

Phase II is a first-line treatment of metastatic colorectal cancer. Use MTD from phase I portion of the trial in patients with locally advanced or metastatic colorectal cancer.

• **C80405**, a phase III, first-line metastatic colorectal cancer trial. It consists of multiple arms: FOLFOX, FOLFIRI, CAPOX, or CAPIRI plus bevacizumab; FOLFOX, FOLFIRI, CAPOX, or CAPIRI plus cetuximab; and FOLFOX, FOLFIRI, CAPOX, or CAPIRI plus both bevacizumab and cetuximab.

• **E2204**, a phase II trial evaluating bevacizumab

in an adjuvant setting for the treatment of pancreatic cancer. This study consists of 4 arms: surgery plus bevacizumab; surgery plus cetuximab; cetuximab plus gemcitabine, capecitabine and radiation treatment; and bevacizumab plus gemcitabine, with capecitabine and radiation treatment.

• **E3201**, a phase III clinical trial for patients with rectal cancer in an adjuvant setting. The trial design consists of four arms: 5-FU/LV (or FOLFIRI); 5-FU/LV (or FOLFIRI) plus bevacizumab; FOLFOX; or FOLFOX plus bevacizumab.

• **E4203**, a phase II, first line therapy for metastatic colorectal cancer study based on tumor thymidylate synthase expression in previously untreated patients with metastatic colon cancer. The study consists of two arms, comparing patients treated with irinotecan, oxaliplatin, and bevacizumab with patients treated with oxaliplatin and bevacizumab.

• **E5202**, a phase III clinical trial using bevacizumab in an adjuvant setting for patients with colon cancer. Molecular markers on tumors are used to place stage II patients in high or low risk categories. The low risk patients are observed, the high-risk patients are randomized to MFOLFOX6 + or – bevacizumab (treatment arms are identical to NSABP C-08).

• **RTOG-H0429**, a phase III trial evaluating the use of cetuximab in head and neck cancers. This study compares the use of AFX-CB or IMRT plus cetuximab and CDDP to AFX-CB or IMRT plus CDDP.

• **NSABP R-04**, for rectal cancer adjuvant setting for patients with stage II/III disease. The design consist of 2 arms: radiation with capecitabine +/- oxaliplatin, and the other arm consists of radiation with 5-FU CVI +/- oxaliplatin.

• **SWOG 0502**, a phase II clinical trial assessing two dose levels of bevacizumab, combined with imatinib, in patients with advanced, incurable gastrointestinal stromal tumors.

Mixed Reactions to CMS Determination

Reactions to the CMS decision were mixed. The American Society of Clinical Oncology and the National Coalition for Cancer Survivorship supported the decision and urged the agency to extend it to other trials, while the Association of Community Cancer Centers characterized the move as inappropriate and called for a change in direction.

"We endorse the decision to cover the cost of the four referenced drugs in the context of nine clinical trials under the sponsorship of NCI," wrote Ellen Stovall, president and CEO of the NCCS.

"The fact that off-label uses of these drugs will also qualify for coverage if supported in the medical compendia ensures that the CMS decision will, in any event, be additive to current coverage and will in no way represent a retreat from statutory coverage standards, as some have feared," Stovall wrote in the letter dated Jan. 28. "We also understand that, at their discretion, Medicare contractors may cover off-label uses based on reports of clinical trials in peer-reviewed medical literature."

ASCO's position is similar. "Today's announcement of a final NCD on off-label uses of colorectal cancer drugs is the latest in a series of innovative coverage analyses that work to promote quality cancer care by giving greater access to life-extending anti-cancer therapies," ASCO President David Johnson wrote in a Jan. 28 letter to CMS. "The decision by CMS today is important to patients because it will ensure that the drugs used in these trials will be available to Medicare patients if pharmaceutical companies do not provide them."

Both NCCS and ASCO said the agency should broaden its policy of paying for approved drugs used beyond NCI sponsored trials.

"Like others, we would recommend that CMS next turn its coverage review to consider the same sort of arrangement with respect to other high quality trials, including those sponsored by the pharmaceutical industry," Stovall wrote in her letter to the agency.

ASCO shares this goal. "We look forward to discussions with CMS about other clinical trials that should be granted similar coverage," Johnson wrote. "Other clinical trials would include: NCI trials in other diseases and involving other drugs; trials sponsored by industry; and trials involving rare or 'orphan' cancers where there is less incentive to study new uses of marketed drugs."

Disagreeing, ACCC said the agency's action exceeds its mandate. "We are concerned that the proposed NCD threatens the Medicare carriers' current coverage policies, which have succeeded at providing timely access to modern cancer therapies; raises myriad unanswered questions about beneficiary access to care inside and outside these trials; and is an inappropriate use of the NCD process to create a profoundly different approach to Medicare coverage of advanced drugs and biologicals."

The association's comments are posted at http://www.accc-cancer.org/news/ncd2.asp

Patterns in CMS Decisions

The colorectal cancer NCD is part of a series

of decisions that indicate that the agency intends to continue to reimburse off-label uses of expensive new therapies and procedures while encouraging collection of data.

Thus, in conjunction with the colorectal cancer NCD, the agency announced the final rule on coverage for PET scanning for cancer diagnosis. The new, expanded PET scan benefit reimburses the test for patients who participate in clinical studies or submit information to a PET database.

"The data collected as part of this policy will help ensure that the PET information is used accurately and appropriately in patient management and will also help doctors and Medicare beneficiaries make better-informed choices about their health care," the agency said.

The PET database is being developed by a working group that includes clinical oncologists, imaging organizations, academic institutions, and the industry, the agency said. According to CMS, coverage will be available "within the next several months," after the database is established.

Reaffirming its reliance on contractors, CMS said it would soon announce the decision to "maintain current policies" for the reimbursement of Zevalin (ibritumomab tiuxetan) and Bexxar (tositumomab), two agents approved for non-Hodgkin's lymphoma.

"This decision will propose to maintain the existing requirement for coverage of these agents as outlined in current law and regulations," the agency said. "Under current policy, coverage of off-label use is based on local coverage policy. Federal law requires that all off-label uses listed in specific compendia must be covered, and other unlisted uses are at contractor discretion."

The agency is conducting three other National Coverage Determinations in cancer:

—The agency has issued a draft NCD on the use of the oral anti-emetic three-drug combination of Emend (aprepitant), a 5-HT3 antagonist, and dexamethasone.

According to the agency's draft memo, the dug combination would be "reasonable and necessary" only to patients who (a) are receiving anti-cancer chemotherapeutic agents defined as level 5 on Hesketh's classification system of acute emetogenicity of anti-cancer chemotherapeutic agents, and (b) have demonstrated unresponsiveness to other anti-emetic regimens not containing aprepitant that are consistent with nationally recognized guidelines associated with prior administration of the same chemotherapy.

—The agency has decided to cover smoking and tobacco use cessation counseling.

Minimal counseling is covered at each evaluation and management visit. Beyond that, Medicare proposes to cover two cessation attempts per year, the draft memo states. Each attempt may include a maximum of four intermediate or intensive sessions, with the total annual benefit covering up to eight sessions in a 12 month period.

"There is evidence that seniors have not been offered smoking cessation treatments at the same frequency as that of younger smokers," the draft memo states. "It is therefore desirable to evaluate the provision of tobacco dependence treatments in the Medicare population, similar to other performance-based measures. CMS will provide well-defined and unique codes to allow the evaluation of per-capita rate of services provided. Additionally, specific codes will allow for the measurement of the processes, outcomes, and patient experiences."

—The agency's review of Plenaxis (abarelix) for palliative treatment of advanced symptomatic prostate cancer would likely reimburse labeled use of the drug.

"All other uses of abarelix therefore are not covered," the draft NCD states. "In light of the concern regarding safety risks of abarelix, off-label uses that may appear in listed statutory drug compendia on which Medicare and its contractors rely to make coverage determinations will remain non-covered until CMS completes a reconsideration of this NCD," the document states.

NIH Policy:

NIH Announces Overhaul Of Ethics Rules For Employees

(Continued from page 1)

since December 2003 raised "real concerns" about the impartiality of scientists involved in paid consultation. The articles led to Congressional investigations that turned up records identifying about 530 NIH scientists who accepted payment, stock, or stock options from biomedical companies from 1999 to 2003, the LA Times reported.

The ban on outside employment includes all 18,000 NIH employees, who now are barred from paid or unpaid positions, including advisory board service, with pharmaceutical and biotechnology companies, supported research institutions, including NIH grantees and CRADA partners, and health care providers and insurers.

Also banned is teaching, speaking, and writing, and sale or promotion of products or services for these

organizations.

The ban extends to membership on boards of directors of health-related non-profit groups, but apparently doesn't prohibit NCI Director Andrew von Eschenbach from serving as vice-chairman of the board of C-Change, a non-profit organization that includes cancer groups and pharmaceutical companies. Anna Barker, NCI deputy director for advanced technologies and strategic partnerships, similarly serves on the C-Change board.

Though C-Change clearly has interest in HHS policy, NIH officials have said in the past that von Eschenbach and Barker serve on the C-Change board in their official capacity and, therefore, their activities cannot be regarded as extracurricular (**The Cancer Letter**, Oct. 1, 2004).

Employees who violate the regulations will be subject to a range of penalties, from a reprimand for minor infractions to removal from their jobs.

Under the regulations, about 6,000 employees and their spouses and children will not be allowed to hold stocks or other investments in pharmaceutical, biotechnology, or medical research and manufacturing companies. Investments in these firms by other employees will be restricted.

However, employees who received stock from such companies as a result of previous employment, such as a pension or benefit, may be permitted to keep it. Also, employees can hold stocks in diversified mutual funds or non-health care sector funds.

The limitation on gifts or awards bars "senior employees"—those with the top policy jobs with the Institutes—from receiving gifts or awards with a market value of more than $200 from any entity that seeks official action from or to do business with NIH, or is substantially affected by NIH.

Senior employees may apply for an exception to receive a major award, such as the Nobel Prize and the Lasker Award.

"Senior employees" are defined as the NIH director and deputy director, senior staff who report directly to the NIH director, the director, deputy director, scientific director, and clinical director of each Institute and Center, extramural program officials who report directly to an Institute or Center director, and "any employee with equivalent levels of responsibility who is designated as a senior employee by the designated agency ethics official or the NIH director."

Lower-level employees can't receive gifts worth more than $200 from an entity with matters pending under their responsibility.

Last year, members of Congress released a list of 122 awards totaling about $575,000, given to NIH employees since 1999, many from institutions that received NIH grants.

Former NCI Director Richard Klausner had accepted a $40,000 prize from the University of Pittsburgh in 1997, despite the recommendation of the NCI ethics officer to decline the award. An HHS lawyer testified to Congress that the department's ethics attorneys were pressured by Clinton Administration officials to allow Klausner to accept the Dickson Prize in Medicine (**The Cancer Letter**, May 21, 2004).

While serving as NCI director, Klausner also accepted the $15,000 Block Lectureship Award from Ohio State University, a $4,000 lecture award from Van Andel Research Institute, and the $3,000 Donald Ware Waddell Award from the Arizona Cancer Center.

Reaction from Congress to the new rules was positive. Rep. Joe Barton (R-Texas), chairman of the House Energy and Commerce Committee, commended Zerhouni "for taking a step that is both difficult and necessary."

The committee's Oversight and Investigations Subcommittee held hearings last year that brought several instances of potential conflicts to light, including the paid consulting by NCI scientist Lance Liotta and FDA microbiologist Emanuel Petricoin for Biospect Inc., a firm that is a competitor of another company, Correlogic Systems Inc., that was working with the scientists under a CRADA (**The Cancer Letter**, May 21, 2004).

"For the National Institutes of Health to do the complex work of thwarting disease and saving lives requires near-absolute public confidence in the people who conduct the research," Barton said. "If the notion that private gain is supplanting public service as the guiding light for health research, NIH's value to our nation will plummet."

The new regulations "should help restore the public's trust that federal biomedical research dollars will be spent wisely and prudently," said Sen. Tom Harkin (D-Iowa).

"NIH's previous ethics requirements were unworkable--not at all what the public deserves from our nation's premier research institution," said Rep. Diana DeGette (D-Colo.) who at one point during the subcommittee's hearings threatened to introduce legislation that would ban consulting and acceptance of awards by NIH employees.

NIH has posted materials on the ethics policy at http://www.nih.gov/about/ethics_COI.htm.

NIH Asks Grantees To Release Papers For Public Database

In its second major policy announcement this week, NIH said it will ask scientists to release manuscripts from research supported by the Institutes for inclusion in a public database with 12 months of publication.

The voluntary policy would improve public access to published articles resulting from NIH-funded research, NIH Director Elias Zerhouni said.

NIH will begin to accept the peer-reviewed publications on May 2 for inclusion in PubMed Central, www.pubmedcentral.nih.gov, managed by the National Library of Medicine.

"While this new policy is voluntary, we are strongly encouraging all NIH-supported researchers to release their published manuscripts as soon as possible for the benefit of the public," Zerhouni said.

The policy requests that beginning May 2, NIH-funded scientists submit an electronic version of the author's final manuscript, upon acceptance for publication, resulting from research supported in whole or in part by NIH. The author's final manuscript is defined as the final version accepted for journal publication, and includes all modifications from the publishing peer review process.

Authors may designate a specific time frame for public release, from immediate public access after final publication to a 12-month delay.

The policy was developed after months of deliberation with professional and patient organizations, and publishers. NIH posted the draft policy for public comment last September and received over 6,000 public comments.

To help implement the policy, NIH plans to establish a Public Access Advisory Working Group, as a subgroup of the NLM Board of Regents.

An NIH fact sheet about the new policy is available at www.nih.gov/about/publicaccess/index.htm.

In Brief:

Myeloma Research Consortium Receives Grant of $1 Million

MULTIPLE MYELOMA Research Consortium received a $1 million grant from Edward and Leslye Phillips. Phillips, son of advice columnist "Dear Abby," is CEO and founder of Millennium Import LLC, and a partner with Moët Hennessy, a division of Louis Vuitton Moët Hennessy. He was diagnosed with the disease in 2003 and is in remission. The donation was given with a request for a matching gift of an additional $1 million by the Multiple Myeloma Research Foundation. . . . **LARRY NORTON**, deputy physician-in-chief for breast cancer programs at Sloan Kettering Cancer Center, will receive the 2005 Herbert and Maxine Block Memorial Lectureship Award for Distinguished Achievement in Cancer from the Ohio State University Comprehensive Cancer Center-Arthur G. James Cancer Hospital and Richard J. Solove Research Institute. Norton is known for his work in cancer genetics and the dose density approach to tumor treatment with chemotherapy. He will present his lecture Feb. 25 at OSU. . . . **KECK SCHOOL OF MEDICINE** at the University of Southern California and the **University of Chicago** received a five-year $9.8 million grant from the U.S. Army Medical Research and Materiel Command for a Breast Cancer Center of Excellence. The Keck School will focus on hormonal carcinogenesis in breast cancer, said **Michael Press**, the Harold E. Lee Chairman in Cancer Research, professor of pathology, and principal investigator. Members of the team are **Brian Henderson**, dean, Keck School of Medicine; **Christopher Haiman**, assistant professor in the Zilkha Neugenetic institute; **Michael Stallcup**, acting chairman of biochemistry and molecular biology and professor of pathology and biochemistry and molecular biology; and **Geoffrey Greene**, associate director of the Ben May Institute for Cancer Research at the University of Chicago. . . . **SCOTT STROME** was appointed chairman of the new Department of Otorhinolaryngology-Head and Neck Surgery at the University of Maryland School of Medicine. He is also chief of otorhinolaryntology at the University of Maryland Medical Center. Strome was associate professor of otorhinolaryntology at Mayo Clinic. The department will expand the clinical and research programs, recruit sinus/skull base surgeons, pediatric ear, nose and throat specialists and physicians specializing in voice disorders as well as immunologists and tumor biologists, said Strome.

CORRECTION: In the list of NCI-designated cancer centers published in the Jan. 28 issue of **The Cancer Letter**, three centers in California were dropped from the list due to an error in a computer file. The centers, their NCI designation and FY 2004 funding, were: University of California, San Diego, Comprehensive, $4.179 million; University of California, San Francisco, Comprehensive, $7.145 million; and University of Southern California, Comprehensive, $6.078 million. The corrected table appears on page 8 of this issue.

Cancer Centers by State (P30 Core Grants), Fiscal Year 2004

(Dollars in Thousands)

State	Grantee Institution	Type	Amount
Alabama	University of Alabama at Birmingham	Comprehensive	$5,525
California	Beckman Research Institute	Comprehensive	2,480
	Burnham Institute	Lab/Basic	3,400
	Salk Institute for Biological Sciences	Lab/Basic	2,900
	University of California Davis	Clinical	1,334
	University of California Irvine	Comprehensive	2,599
	University of California Los Angeles	Comprehensive	4,584
	University of California San Diego	Comprehensive	4,179
	University of California San Francisco	Comprehensive	7,145
	University of Southern California	Comprehensive	6,078
Colorado	University of Colorado Health Sciences Center	Comprehensive	3,563
Connecticut	Yale University	Comprehensive	1,039
District of Columbia	Georgetown University	Comprehensive	2,832
Florida	University of South Florida/ H. Lee Moffitt Cancer Center	Comprehensive	2,410
Hawaii	University of Hawaii at Manoa	Clinical	2,125
Illinois	Northwestern University	Comprehensive	4,873
	University of Chicago	Clinical	3,788
Indiana	Indiana University - Purdue University at Indianapolis	Clinical	1,200
	Purdue University West Lafayette	Lab/Basic	1,262
Iowa	University of Iowa	Comprehensive	1,373
Maine	Jackson Laboratory	Lab/Basic	2,775
Maryland	Johns Hopkins University	Comprehensive	5,975
Massachusetts	Dana-Farber Cancer Institute	Comprehensive	10,514
	Massachusetts Institute of Technology	Lab/Basic	2,551
Michigan	University of Michigan at Ann Arbor	Comprehensive	5,184
	Wayne State University	Comprehensive	500
Minnesota	Mayo Clinic Rochester	Comprehensive	5,000
	University of Minnesota Twin Cities	Comprehensive	3,350
Missouri	Washington University	Clinical	4,062
Nebraska	University of Nebraska Medical Center	Clinical	1,522
New Hampshire	Dartmouth College	Comprehensive	2,944
New Jersey	Robert Wood Johnson Medical School	Comprehensive	2,550
New York	American Health Foundation/ Inst for Cancer Prevention	Lab/Basic	2,713
	Cold Spring Harbor Laboratory	Lab/Basic	3,855
	Columbia University Health Sciences	Comprehensive	1,842
	Kaplan Cancer Center/NYU	Clinical	2,575
	Roswell Park Cancer Institute Corp	Comprehensive	3,781
	Sloan-Kettering Institute for Cancer Research	Comprehensive	9,943
	Yeshiva University	Clinical	3,928
North Carolina	Duke University	Comprehensive	5,838
	University of North Carolina Chapel Hill	Comprehensive	5,544
	Wake Forest University	Comprehensive	1,322
Ohio	Case Western Reserve University	Comprehensive	4,318
	Ohio State University	Comprehensive	2,757
Oregon	Oregon Health & Science University	Clinical	1,260
Pennsylvania	Fox Chase Cancer Center	Comprehensive	7,952
	Thomas Jefferson University	Clinical	4,441
	University of Pennsylvania	Comprehensive	5,543
	University of Pittsburgh at Pittsburgh	Comprehensive	5,000
	Wistar Institute	Lab/Basic	2,664
Tennessee	St. Jude Children's Research Hospital	Clinical	4,970
	Vanderbilt University	Comprehensive	5,100
Texas	San Antonio Cancer Institute	Clinical	2,834
	University of Texas M.D. Anderson Cancer Center	Comprehensive	9,497
Utah	Huntsman Cancer Institute/University of Utah	Clinical	800
Vermont	University of Vermont & St. Agric College	Comprehensive	1,348
Virginia	University of Virginia Charlottesville	Clinical	1,065
	Virginia Commonwealth University/Massey Cancer Center	Clinical	1,865
Washington	Fred Hutchinson Cancer Research Center	Comprehensive	9,927
Wisconsin	University of Wisconsin Madison	Comprehensive	5,521
	Total P30s	61	233,648

Copying Policy for The Cancer Letter Interactive

The software that comes with your issue allows you to make a printout, intended for your own personal use. Because we cannot control what you do with the printout, we would like to remind you that routine cover-to-cover photocopying of The Cancer Letter Interactive is theft of intellectual property and is a crime under U.S. and international law.

Here are guidelines we advise our subscribers to follow regarding photocopying or distribution of the copyrighted material in The Cancer Letter Inc. publications in compliance with the U.S. Copyright Act:

What you can do:

--Route the printout of the newsletter to anyone in your office.

--Copy, on an occasional basis, a single story or article and send it to colleagues.

--Consider purchasing multiple subscriptions. Contact us for information on multiple subscription discounts.

What you can't do without prior permission:

--Make copies of an entire issue of the newsletter. The law forbids cover-to-cover photocopying.

--Routinely copy and distribute portions of the newsletter.

--Republish or repackage the contents of the newsletter.

We can provide reprints for nominal fees. If you have any questions or comments regarding photocopying, please contact Publisher Kirsten Boyd Goldberg, phone: 202-362-1809.

We welcome the opportunity to speak to you regarding your information needs.