

Healthcare Provider Perspectives on the Phlebotomy Visit Workflow in Polycythemia Vera and Associated Healthcare Resource Utilization in the United States

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Background	Methods	Results		Conclusions																					
- Polycythemia vera (PV) is a chronic myeloproliferative neoplasm characterized by excessive red blood cell production and elevated hematocrit (HCT)^{1,2} - Treatment aims to maintain HCT <45% and reduce thrombotic and cardiovascular risk. Phlebotomy (PHL), with low-dose aspirin, is currently standard of care for PV management³ - Understanding the burden and healthcare resource utilization associated with PHL is important for contextualizing the value of future treatment innovations	- Qualitative, double-blind, cross-sectional study included two rounds of individual semi-structured virtual interviews (March-June 2026) with 20 healthcare providers (HCPs; 6 physicians, 14 nurses) experienced with PHL for PV in outpatient or infusion/cancer centers, with interviews conducted until thematic saturation was achieved (≥2 successive interviews with no new insights or meaningful deviations from the core process) - Detailed information was collected on the PHL visit workflow, including time estimates, as well as HCP perspectives on satisfaction, challenges and complexities, and steps that could be alleviated by a home-based treatment with a reduced PHL need	Figure 1: Participant characteristics <table><tr><th>Center characteristics, n%</th><th>Physicians (N = 6)</th><th>Nurses (N = 14)</th></tr><tr><td>Setting</td><td>3 (50%) Academic 3 (50%) Community</td><td>6 (43%) Academic 8 (57%) Community</td></tr><tr><td>Clinic type</td><td>3 (50%) Outpatient clinic 3 (50%) Cancer center</td><td>3 (21%) Outpatient clinic 11 (79%) Infusion or cancer center</td></tr><tr><td>PHL location</td><td>5 (83%) On-site 1 (17%) Off-site</td><td>13 (93%) On-site 1 (7%) Off-site</td></tr><tr><th>HCP characteristics, n%</th><td></td><td></td></tr><tr><td>Medical specialty/role</td><td>3 (50%) Medical oncology 3 (50%) Hematology-oncology</td><td>11 (79%) Nurse practitioner 3 (21%) Registered nurse</td></tr><tr><td>Annual number of patients with PV, range Mean [median]</td><td>15-80 32 [24]</td><td>5-100 40 [28]</td></tr></table>	Center characteristics, n%	Physicians (N = 6)	Nurses (N = 14)	Setting	3 (50%) Academic 3 (50%) Community	6 (43%) Academic 8 (57%) Community	Clinic type	3 (50%) Outpatient clinic 3 (50%) Cancer center	3 (21%) Outpatient clinic 11 (79%) Infusion or cancer center	PHL location	5 (83%) On-site 1 (17%) Off-site	13 (93%) On-site 1 (7%) Off-site	HCP characteristics, n%			Medical specialty/role	3 (50%) Medical oncology 3 (50%) Hematology-oncology	11 (79%) Nurse practitioner 3 (21%) Registered nurse	Annual number of patients with PV, range Mean [median]	15-80 32 [24]	5-100 40 [28]	HCP perspectives on main challenges associated with PHL Operational complexity and burden - PHL involves a multi-step, resource-intensive workflow requiring coordination across administrative, laboratory, physician, and nursing teams (Figure 2) - In addition to chair time, PHL requires continuous nursing supervision throughout the procedure - Because PHL is triggered by HCT results, scheduling is reactive and unpredictable, leading to occasional same-day cancellations and unused clinical capacity - In centers operating near capacity, delays in coordinating HCP and chair availability prolonged visit times Burden on patients - HCPs perceived PHL to impose a substantial patient burden, including frequent visits, logistical challenges, procedure-related anxiety, and PHL-related symptoms (e.g., dizziness) Procedural challenges - Challenges may include difficult venous access, increased blood viscosity, the need for hydration procedure, and management of PHL-related symptoms, contributing to extended chair and nurse-attended time Lack of long-term durability - Although viewed as effective for short-term HCT control by physicians, long-term disease management often required repeated PHL and the addition of cytoreductive therapy Physician perspective on a home-based treatment with a reduced PHL need Optimization of operational efficiency - Physicians anticipated reduced nursing supervision and chair occupancy compared with PHL, making these resources available for other patient care services, though a similar frequency of laboratory monitoring and physician visits was expected - Reduced reliance on in-clinic, procedure-driven, same-day scheduling could reduce operational uncertainty, streamline workflows, increase chair availability, and minimize unused clinical capacity Improved patient convenience - Home-based treatment may help reduce travel burden and minimize disruption to patients' daily activities, including by providing greater flexibility in where patients undergo laboratory monitoring Openness to home-based treatment - All physicians (100%) expressed openness to home-based treatment options that could reduce or eliminate the need for PHL	- Although PHL is a cornerstone of PV management, it remains reactive to elevated HCT levels and provides only short term HCT control; residual thrombotic and cardiovascular risk may persist. Long-term PV management often requires repeated PHL and additional therapy - PHL is time consuming and resource-intensive from a healthcare system perspective, with notable HCP and patient burden - Alternative home-based treatments with a reduced PHL need may improve workflow efficiency and logistics for patients by minimizing in-clinic procedures and simplifying care delivery - Additional insights from the patient perspective (e.g., travel time, recovery time) can expand these findings to understand the full time burden of PHL
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Objective																									
To evaluate phlebotomy visit workflow and associated healthcare resource utilization in PV from a US healthcare system perspective																									

