Table 1. Priorities for Breast Disease Focused Outpatient Visits

Priority A	Priority B	Priority C
Potentially unstable (e.g., hematoma, infection/abscess)	New diagnosis of noninvasive cancer—convert as many visits to telemedicine visits	Established patients with no new issues
New Diagnosis of invasive cancer--may convert to telemedicine visit	Post-op Patients	Survivorship visits
	Established patients with new problems or symptoms from treatment—convert as many visits to telemedicine visits as possible	Patients at high risk for breast cancer (BRCA carriers, etc.)
		Well patient visits
		Benign breast follow-up visits (including atypia and other benign lesions)

Table 2. Priorities for Breast Disease Focused Imaging

Priority A	Priority B	Priority C
none	Diagnostic imaging for breast symptoms or a BIRADS 4-5 screening mammogram	Routine screening can be deferred until the COVID-19 pandemic resolves—It is reasonable for patients in the general population to defer screening mammography for 6-12 months, a deferral that is not likely to have an impact on overall survival.
	Biopsies for abnormal mammograms or breast symptoms	Patients with abnormal screening mammograms who can go to 6 month interval imaging.
		Defer all screening with other modalities such as MRI or breast US

Table 3. Priorities for Breast Disease Focused Surgical Oncology

Priority A	Priority B	Priority C
Incision and drainage of a breast abscess	Neoadjuvant patients finishing treatment	Excision of benign lesions—fibroadenomas, nodules, etc.
Evacuation of hematoma	Clinical stage T2 or N1 ER positive/PR positive/HER2 negative tumors—some of these patients can receive hormonal therapy	Duct excisions
Revision of ischemic mastectomy flap	Triple negative and HER2 positive patients—In some cases institutions may decide to proceed with surgery versus subjecting a patient to an immunocomprised state, these decisions will depend on institutional resources	Discordant biopsies likely to be benign
Revascularization/revision of autologous tissue flap—autologous reconstruction should be deferred	Reconstructive surgery should be limited to tissue expander or implant placement—autologous reconstruction should be deferred	High risk lesions—atypia, papillomas, etc.
	Discordant biopsies likely to be malignant	Prophylactic surgery—for cancer and noncancer
	Excision of malignant recurrence	Delayed sentinel node biopsy for cancer identified on excisional biopsy
	Provided that radiation oncology services are available and the risk of multiple visits or deferred radiation is acceptable, eligible patients should have breast conservation. Elective mastectomy with or without reconstruction may be preferred but should be deferred until after the COVID-19 pandemic resolves	ER positive and ER negative DCIS
		Re-excision surgery
		Tumors responding to neoadjuvant hormonal therapy
		Clinical Stage I ER positive/PR positive/HER2 negative cancers—these patients can receive hormonal therapy***** **and****

Table 4. Priorities for Breast Cancer Focused Medical Oncology

Priority A	Priority B	Priority C
Neoadjuvant/adjuvant chemotherapy for triple negative and HER2 positive breast cancer	*Higher Priority:* Use of neoadjuvant endocrine therapy to enable deferral of surgery by 6-12 months in clinical stage 1 or 2 breast cancers. Many women with early stage, ER positive breast cancers do not benefit substantially from chemotherapy. In general, these include women with stage 1 or limited stage 2 cancers, particularly those with low-intermediate grade tumors, lobular breast cancers, low OncotypeDX®scores (<250, or "luminal A" signatures. High level evidence supports the safety and efficacy of 6-12 months of primary endocrine therapy before surgery in such women, which may enable the deferral of surgery.	Antiresorptive therapy (zoledronic acid, denosumab) that is not needed urgently for hypercalcemia
Early line chemotherapy likely to improve outcomes in metastatic disease	*Higher Priority:* for HER2 positive breast cancer: Adjuvant antibody treatment may reasonably be curtailed after 7 months instead of 12 months of treatment as randomized trials show narrow benefits of longer (12M) durations as compared to shorter durations.	Follow-up imaging, restaging studies and some echocardiograms and ECGs can be delayed or done at lengthened intervals if clinically stable
Completion of neoadjuvant/adjuvant chemotherapy (with or without anti-HER2 therapy) that has already been initiated	*Lower priority:* Later line palliative chemotherapy that is less likely to improve outcomes	Port flush can go to 12 weeks or longer
Continuation of standard adjuvant endocrine therapy with oral agents such as tamoxifen or aromatase inhibitors	*Lower priority:* Antibody treatment (i.e., treastuzumab,pertuzumab) for metastatic, HER2 positive breast cancer beyond two years of maintenance in patients with minimal disease burden (follow	In carefully selected patients, particularly those with ER positive breast cancer, radiation therapy may be delivered before chemotherapy without compromising long term

	for progression every 3-6 months)	survival, if this facilities patient safety.
LHRH agonists in the adjuvant or metastatic setting to ensure optimal endocrine therapy	In stage 1, HER2 positive breast cancers, clinicians may substitute trastuzumab-DM1 instead of paclitaxel/trastuzumab for patient safety or convenience based on randomized trial data	
	Consider delaying addition of CDK4/6, mTOR, or PIK3CA inhibitors or endocrine therapy, particularly in first line and/or situations where endocrine therapy alone is providing effective tumor control	
Adjusting and Optimizing Treatment Dosing or Scheduling		
Chemotherapy schedules may be modified so as to reduce clinical visits (for instance, using 2 or 3 week dosing instead of weekly dosing for selected agents when appropriate. Patients should receive G-CSF growth factor support so as to minimize neutropenia, while dexamethasone use should be limited as appropriate to reduce immunosuppression.	Neoadjuvant endocrine therapy: Based on randomized trials, preoperative treatment with an aromatase inhibitor may offer clinical benefit over tamoxifen in post-menopausal women. For pre-menopausal women, LHRH agonist should be used, and aromatase inhibitors are preferred over tamoxifen. Home administration of LHRH agonists by patient or visiting nursing may be considered where that is an option.	
Anti-HER2 therapies: Trastuzumab and pertuzumab are unlikely to affect immune function and should be safe for patients.	Anti-HER2 therapies: Antibody treatment in metastatic setting may reasonable be liberalized to longer intervals (e.g., 4 weeks)	
LHRH agonists may be given with long-acting targeting agents (eg., CDK4/6 inhibitors, mTOR inhibitors, PIK3Ca inhibitors). Use of oral targeted agents every 3 month dosing, to reduce patient visits or alternatively, home administration of LHRH agonists by patient or visiting nursing may be considered where that is an option.	Oral targeting agents (e.g. CDK4/6 inhibitors, mTOR inhibitors, PIK3Ca inhibitors). Use of oral targeted agents must be weighed against the increased risk of adverse events which may increase interaction with healthcare centers and staff. Doses may be reduced to optimize tolerability and minimize treatment related toxicities.	

Endocrine therapies: Oral agents used widely in adjuvant or metastatic setting (e.g., tamoxifen, aromatase inhibitors) should have no effect on immune function and can be safely continued. Fulvestrant should have no effect on immune function but requires monthly clinical administration.		

Table 5. Priorities for Breast Cancer Focused Radiation Oncology

Priority A	**Priority B**	**Priority C**
Bleeding/painful inoperable breast mass	Category 1: Adjuvant post-operative breast cancer patients within 16 weeks of last surgery or chemotherapy with high risk indications for radiation such as inflammatory disease, node positive disease, triple negative breast cancer, post neoadjuvant chemotherapy with residual disease at surgery, young age (<40 years) with additional high-risk features	Patients over age 65-70 years of age with lower risk Stage I hormone receptor positive/HER2 negative cancers and taking adjuvant endocrine therapy can be encouraged to defer/omit radiation without affecting overall survival. If patient cannot tolerate endocrine therapy, re-evaluate for radiation depending on individual patient and pathologic factors and current severity of pandemic. Invasive cancers should be prioritized over DCIS.
Patients already on treatment	Category 2: Adjuvant postoperative breast cancer patients within 3-6 months of last surgery or chemotherapy with low-to-intermediate/intermediate risk indications for radiation, such as age <65 years, and age I/II luminal cancer, ER+ node positive, or positive margins—use of hypofractionation where clinically appropriate is recommended to reduce visits.	Women with DCIS may omit radiation therapy, especially those with ER positive lesions taking endocrine therapy, without affecting overall survival.
Patients with spinal cord compression, brain metastases, or other critical metastatic lesions.		