Planning Considerations for Transitioning from Inpatient to Outpatient Care/Academic to Community Settings

- Establish strong relationships between clinicians at academic and community cancer programs
- Establish clear referral pathways and protocols for the transition from inpatient to outpatient administration
  - Build on existing referral pathways (eg, for stem cell transplant or clinical trials)
- Ensure office staff are familiar with referral process
- Create an online resource to help prepare patients to receive initial treatment at an academic medical center and follow-up care with a local oncologist
- Create a patient information sheet that clearly outlines team members and their roles and responsibilities across the different sites of care
- Use telehealth to provide follow-up care, remote vital sign monitoring, and symptom monitoring
- Coordinate with local providers for patients who live further away from academic or tertiary care centers
- Connect patients with navigators who know how to coordinate logistics between community cancer programs and academic medical centers, if available

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CD20 X CD3 Bispecifics—Redefining Treatment for Patients with R/R DLBCL/LBCL in the Community Setting

A PATIENT/CLINICIAN DECISION SUPPORT AID

What is Shared Decision-Making?

Shared decision-making (SDM) occurs when a healthcare provider and a patient work together to make a healthcare decision that is best for the patient. Optimal decision-making takes into account evidence-based information about available options; the provider's knowledge and experience; and the patient's values, goals, and preferences. Patients and their families/caregivers who are engaged in an SDM process are more likely to arrive at a treatment decision that works best for all those involved.

The SHARE Decision-Making Approach

STEP 1 SEEK your patient's participation.

STEP 2 HELP your patient explore & compare treatment options.

STEP 3 ASSESS your patient's values and preferences.

STEP 4 REACH a decision with your patient.

STEP 5 EVALUATE your patient's decision.

AHRQ. The SHARE Approach. https://www.ahrq.gov/health-literacy/professional-training/shared-decision/index.html

Advantages of Bispecific Antibodies Compared to CAR T-Cell Therapy

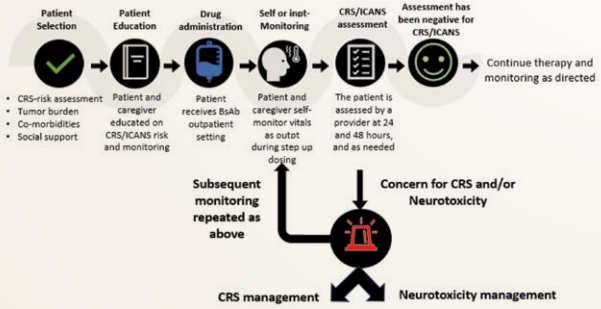
- Readily available, "off-the-shelf" products
  - No treatment delay for leukapheresis and manufacturing
  - Do not require bridging therapy
  - Administered SC or IV
- Lower rates of severe side effects (grade ≥3 CRS and neurotoxicity)
- Demonstrated activity in patient populations including
  - Patients with rel/ref DLBCL after receiving CAR T-cell therapy
  - Older patients
  - Patients with multiple prior lines of therapy
  - Patients who are not eligible for CAR T-cell therapies

Evidence Supporting CD20 X CD3 Bispecifics in DLBCL/LBCL

Agent	Epcoritamab	Glofitamab	Mosunetuzumab	Odronextamab	Plamotamab
Configuration CD20:CD3	1:1	2:1	1:1	1:1	1:1
Administration	SC	IV	IV / SC*	IV	IV
Dosing	Step-up	Step-up	Step-up	Step-up	Step-up
CD20 Ab lead-in**	No	Yes	No	No	No
Fixed or continuous dosing	Continuous	Fixed	Fixed	Continuous	Continuous
Post-dose steroids	Yes	No	No	No	No
Inpatient stay (24 hours) after cycle 1 step-up dose***	Yes	Yes	No	Unknown	Unknown
FDA approval	Rel/ref DLBCL-NOS including DLBCL arising from indolent lymphoma, and high-grade B-cell lymphoma after ≥2 lines of therapy	Rel/ref DLBCL-NOS or LBCL arising from FL after ≥2 lines of therapy	Rel/ref FL after ≥2 lines of therapy	-	-
ORR	63%	56%	42%	-	-
CR rate	39%	44%	24%	-	-
All grade CRS	50%	64%	26%	-	-

*Under investigation, not approved.
**Lead-in requirement prior to step-up dosing as a side effect/CRS mitigation strategy.
***Because of the risk of CRS and ICANS.
Ab, antibody; CD, cluster of differentiation; CR, complete response; CRS, cytokine release syndrome; DLBCL, diffuse large B-cell lymphoma; FL, follicular lymphoma; IV, intravenous; LBCL, large B-cell lymphoma; NOS, not otherwise specified; ORR, overall response rate; SC, subcutaneous.

When to Consider Bispecific: Have a Plan



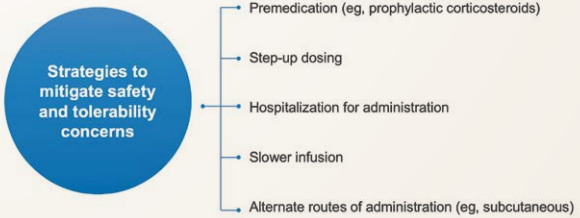
Crombie JL, et al. *Blood*. 2024;143(16):1565-1575.
BsAb, bispecific antibodies; CRS, cytokine release syndrome; ICANS, immune effector cell-associated neurotoxicity syndrome; inpt, inpatient.

Team-Based Strategies for Care Coordination and Communication

When to Consider Bispecific				
Patient selection	**NOT eligible for CAR-T**	**Post CAR-T**		
	• Comorbid conditions • Access constraints • Disease constraints	• Super Refractory: Relapse within 100 days (non-trial population for epco/glofit) • Refractory: Relapsed within 6 months (trial population for epco/glofit) • Relapse: >6 months from CAR-T		• Patient Preference
Site readiness	**Management Team**	**Bispecific Specific**		**Facility Logistics**
	• Patient • Caregiver • Nurse Champions • APP • Physician • Pharmacist • Administrator	• Outpatient vs inpatient dosing • Timing of monitoring • When to call • Monitoring of vitals - BP cuff, thermometer, pulse ox • Laboratory evaluation		• Communication with the hospital system - ER, Inpatient Unit, On-call team, Pharmacy • Supportive meds availability - Steroids, tocilizumab • Distance from tocilizumab - 30-60 minutes • Patient-specific plan vs system plan
Treatment sequencing	**CD20 exposure only**	**Early CAR-T (2nd Line)**	**Late CAR-T (3rd Line)**	**Novel NO CAR-T (4th Line)**
	Multi-chemo refractory; ex: Pola-R-CHP; R-ICE	Chemo to CAR-T; ex: R-CHOP to Liso-cel/ Axi-cel	Multi-chemo relapsed; ex: R-CHOP, R-ICE → HDT-ASCR; CAR-T	Ex: mini-R-CHOP; Tafa-Len; Lonca-T

APP, advanced practice provider; Axi-cel, axicabtagene ciloleucel; BP, blood pressure; CAR-T, chimeric antigen receptor T-cell therapy; CD, cluster of differentiation; ER, emergency room; HDT-ASCR, high-dose chemotherapy and autologous stem cell rescue; Liso-cel, lisocabtagene maraleucel; Lonca-T, loncastuximab tesirine; ox, oximeter; Pola, polatuzumab; R-CHP, rituximab, cyclophosphamide, doxorubicin, and prednisone; R-CHOP, rituximab, cyclophosphamide, doxorubicin hydrochloride, vincristine, and prednisone; R-ICE, rituximab plus ifosfamide, carboplatin, and etoposide; Tafa-Len, tafasitamab plus lenalidomide.

Addressing Adverse Events with Bispecific Antibodies



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