NCODA

NCODA Resource Guide

Clinical Resources

PQIs: STANDARDIZING EXCELLENCE IN MEDICALLY INTEGRATED ONCOLOGY CARE

As oncology treatment continues to evolve at a rapid pace, maintaining consistency, safety and evidence-based best practices across multidisciplinary teams can be challenging.

New oral oncolytics, complex dosing strategies, toxicity profiles, biomarker-driven indications and sequencing considerations require coordinated, informed decision-making at every step. NCODA's Positive Quality Interventions (PQIs) were developed to help oncology professionals meet that challenge.

A PQI is a peer-reviewed, clinically grounded guidance framework focused on a specific therapy or clinical scenario. Each PQI distills available evidence, prescribing information and real-world expertise into practical, actionable standards that support optimal therapy selection, dosing, monitoring, toxicity management and patient education.

PQIs are designed for use by the entire medically integrated oncology team — physicians, pharmacists, nurses, advanced practitioners, administrators and care coordinators — reinforcing shared accountability and standardized excellence across disciplines.

Unlike traditional guidelines that may focus primarily on disease state management, PQIs emphasize safe, operational implementation. They provide clarity around dose modifications, supportive care strategies, monitoring parameters, drug-drug interactions, adherence considerations and workflow integration. Many PQIs are accompanied by practical tools that can be embedded into treatment pathways, EMR templates, and patient education processes, helping reduce variability and administrative burden while enhancing quality.

To see one of NCODA's latest PQIs — **HER2 Immunohistochemistry Testing in Metastatic Breast Cancer: Guiding Treatment Decisions and the Role of Sacituzumab Govitecan** — please turn the page.

AVAILABLE PQIs

NCODA's PQI library continues to expand as new therapies and clinical insights emerge. Some of our more recent PQIs include:

- **Epcoritamab (Epkinly™)** — Relapsed/Refractory Diffuse Large B-Cell Lymphoma and Follicular Lymphoma
- **Ivosidenib (Tibsovo®)** — Management of IDH1 Mutant Acute Myeloid Leukemia
- **Encorafenib (Braftovi®) + Cetuximab (Erbitux®) + mFOLFOX6** — BRAF V600E-Positive Metastatic Colorectal Cancer
- **Elranatamab (Elrexfio®)** — Relapsed/Refractory Acute Myeloid Leukemia
- **Amivantamab (Rybrevant®) and Lazertinib (Lazcluze®)** — Prophylaxis and Management of Skin Toxicities: The COCOON Protocol
- **Revumenib (Revuforj®)** — Management of Acute Leukemia
- **Sutimlimab-jome (Enjaymo®)** — Management of Hemolysis in Cold Agglutinin Disease (CAD)
- **Datopotamab deruxtecan (Datroway®)** — Prophylaxis and Management of Adverse Events

For a full list of available NCODA PQI's, go to **www.ncoda.org/find-a-pqi/**.

Each PQI is developed through NCODA's collaborative model, leveraging the expertise of practicing oncology professionals who understand the operational and clinical realities of cancer care. This peer-to-peer development process ensures relevance, practicality and alignment with medically integrated oncology practice.

WHY PQIS MATTER TO YOUR PRACTICE

For NCODA members, PQIs serve as quality anchors. They promote proactive toxicity management, encourage therapy adherence, reduce unnecessary dose interruptions and support value-based care initiatives. Standardizing evidence-based interventions across teams can also strengthen documentation, improve communication with payers and support performance improvement efforts.

For prospective members, PQIs represent a tangible example of NCODA's commitment to advancing patient-centered, medically integrated oncology care. They are not theoretical position statements — they are working tools designed for everyday use in clinical practice.

As oncology continues to grow more complex, the need for structured, practical quality frameworks becomes even more critical. PQIs help ensure that patients receive the right therapy, delivered safely and effectively, within a coordinated care model that prioritizes outcomes and accountability.

NCODA will continue expanding the PQI portfolio in response to emerging therapies and member-driven needs. For oncology professionals seeking to standardize excellence and elevate care delivery, PQIs offer a clear, actionable pathway forward.

Written By: Sydney Schultz, PharmD, BCOP
Institution: Mayo Clinic

HER2 Immunohistochemistry Testing in Metastatic Breast Cancer: Guiding Treatment Decisions and the Role of Sacituzumab Govitecan

Description:
The purpose of this document is to discuss the clinical utility and implications of human epidermal growth factor receptor 2 (HER2) immunohistochemistry (IHC) testing in metastatic triple-negative breast cancer (mTNBC) and metastatic hormone receptor-positive HER2-negative (mHR+/HER2-) breast cancer. It also reviews current treatment approaches for these two subsets of metastatic breast cancer, with a focus on the role of sacituzumab govitecan (SG).

Background:

- HER2 is commonly overexpressed on the surface of breast cancer cells and HER2 testing should be performed on all new primary or newly metastatic breast cancers[1]
- HER2 testing occurs in a two-step process: first with IHC, then with in-situ hybridization (ISH) testing if IHC results are uncertain or equivocal (see table below)[1,2]

Table 1. HER2 protein expression by IHC assay[1,2]

Score	Description	Interpretation
0	No membrane staining observed	HER2 negative/null
0+	Faint/barely perceptible incomplete staining in <10% of tumor cells	HER2 ultralow Treat as HER2 negative
1+	Faint/barely perceptible incomplete membrane staining in >10% of tumor cells	HER2 low Treat as HER2 negative
2+	Weak to moderate complete membrane staining in >10% of tumor cells Or Complete membrane staining that is intense but within ≤10% of tumor cells	HER2 equivocal → reflex to FISH testing If ISH negative: HER2 low If ISH positive: HER2 positive
3+	Intense, complete circumferential membrane staining in >10% of tumor cells	HER2 positive

- HER2-negative and HER2-low (IHC 1+ or 2+/FISH negative) tumors may be considered for treatment with antibody drug conjugate (ADC) therapy, including SG, in the second line or beyond setting
- In the phase III ASCENT trial[4] (SG vs physician choice, single-agent chemotherapy in mTNBC patients)
    - SG improved PFS and OS in both HER2 IHC0 and HER2-Low patients
    - ORR was improved for SG vs chemotherapy in HER2 IHC0 and HER2-Low patients

PQI Process:

- Confirm HER2 and HR status
- Evaluate prior lines of therapy and performance status
- Determine appropriate treatment recommendations based on patient's biomarker results and treatment history

Table 2. Guideline-Recommended Treatment for mTNBC[1]

Setting	Biomarker	Regimens
First Line	PD-L1 CPS ≥ 10 regardless of germline BRCA 1/2 mutation status	• Chemotherapy + Pembrolizumab (category 1, preferred) • **Sacituzumab govitecan** + pembrolizumab **(preferred)**
	PD-L1 CPS < 10; no germline BRCA 1/2 mutation	• **Sacituzumab govitecan (category 1, preferred)** • Datopotamab deruxtecan (other recommended) • Systemic chemotherapy
Second Line	Germline BRCA 1/2 mutation	• PARP inhibitor (category 1, preferred)
	Any	• **Sacituzumab govitecan (category 1, preferred)** • Systemic chemotherapy or targeted agents
	No germline BRCA 1/2 mutation HER2 IHC 1+ or 2+/FISH-	• Fam-trastuzumab deruxtecan *(other recommended regimen)*

Table 3. Guideline-Recommended Treatment for endocrine refractory mHR+/HER2-negative disease[1]

Setting	Biomarker	Regimens
Second Line	HER2 IHC 1+ or 2+/ISH negative	• Fam-trastuzumab deruxtecan (category 1, preferred)
	HER2 IHC 0+	• Fam-trastuzumab deruxtecan (other recommended regimen)
	Not a candidate for fam-trastuzumab deruxtecan	• **Sacituzumab govitecan (category 1, preferred)** • Systemic chemotherapy • Targeted therapy • For HER2 IHC 0, 1+, or 2+/FISH negative: Datopotamab deruxtecan *(other recommended regimen)*

If proceeding with SG[3]:

- SG is a trophoblast cell-surface antigen 2 (TROP2) directed ADC linked to a topoisomerase I inhibitor chemotherapy payload
- TROP2 does not require biomarker testing; it is found in high amounts of the surface of breast cancer cells
- Administer SG 10 mg/kg IV on Days 1 and 8 of a 21-day cycle
- Boxed warnings for diarrhea and neutropenia
- Patients with UGT1A1*28 genotype and reduced UGT1A1 activity and are at increased risk for toxicity
- High emetic risk: provide prophylactic antiemetics
- Risk of febrile neutropenia: provide primary G-CSF prophylaxis if patient has additional risk factors (prior chemotherapy, age > 65, renal dysfunction, etc)

Patient-Centered Activities:

- Discuss the importance and implications of HER2 testing, including how results influence treatment selection
- Review the NCODA PQI document, *Sacituzumab govitecan: Prophylaxis and Management of Adverse Events*, prior to providing patient education
- Provide chemotherapy patient education sheet for sacituzumab govitecan
- Reinforce importance of early symptom reporting (e.g., diarrhea, nausea/vomiting, fever, fatigue)

References:

1. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Breast Cancer. V.4.2025.
2. Wolff AC, Somerfield MR, Dowsett M, et al. Human Epidermal Growth Factor Receptor 2 Testing in Breast Cancer: ASCO-College of American Pathologists Guideline Update. J Clin Oncol. 2023 Aug 1;41(22):3867-3872. doi: 10.1200/JCO.22.02864.
3. Trodelvy® (sacituzumab govitecan) [prescribing information]. Foster City, CA: Gilead Sciences Inc; March 2025.
4. Bardia A, Rugo HS, Tolaney SM, et al. Final Results From the Randomized Phase III ASCENT Clinical Trial in Metastatic Triple-Negative Breast Cancer and Association of Outcomes by Human Epidermal Growth Factor Receptor 2 and Trophoblast Cell Surface Antigen 2 Expression. J Clin Oncol. 2024 May 20;42(15):1738-1744. doi: 10.1200/JCO.23.01409.

PQI IN ACTION

Positive Quality Intervention

NCODA

Zolbetuximab (Vyloy®) for Gastroesophageal Cancers

Now Available!
Scan QR Code
To View

To view all PQI in Action articles, visit: www.ncoda.org/pqi-in-action

POSITIVE QUALITY INTERVENTIONS IN ACTION: TRANSLATING STANDARDS INTO PRACTICE

Positive Quality Interventions (PQIs) are concise, peer-reviewed clinical guidance tools that define quality standards and effective practices around specific aspects of cancer care.

By equipping multidisciplinary oncology teams with evidence-based recommendations, PQIs support safe and consistent management of patients receiving oral or IV oncolytic therapies.

Their practical companions — PQIs in Action (PQIiA) — illustrate how those standards are implemented in real-world oncology practices.

While PQIs establish the clinical framework, PQIiAs bring those standards to life through expert insight, workflow adaptation and multidisciplinary collaboration. Together, they form a dynamic quality resource grounded in both evidence and experience.

FROM GUIDANCE TO IMPLEMENTATION

PQIiAs are developed by oncology professionals actively engaged in patient care. Pharmacists, physicians, advanced practice providers, nurses and administrators contribute frontline expertise, offering examples of how PQI recommendations are operationalized within medically integrated practices.

To read the full **PQI In Action on DAROLUTAMIDE (NUBEQA®)**, scan the QR code above.

Each PQIiA reflects not only clinical knowledge but also the practical realities of workflow design, patient education, therapy monitoring and care coordination.

Content is peer-reviewed and shaped through collaboration with NCODA member experts and review committees to ensure clinical accuracy, applicability and consistency. Contributions often incorporate perspectives from multiple organizations and practice settings, reinforcing the multidisciplinary nature of oncology care.

More than a procedural summary, a PQIiA provides context. It addresses common barriers to implementation, highlights lessons learned and shares adaptable strategies that other practices can replicate. As the library continues to expand, more than several dozen PQIiAs have been produced to date, with new topics added regularly as therapies and practice standards evolve.

This PQI In Action on Darolutamide (Nubeqa®) was produced in cooperation with the Fred Hutchinson Cancer Center, Utah Cancer Specialists, The Start Center Pharmacy, Texas Oncology and GW Medicine. This guide is one of the most recent PQI In Action documents available through NCODA. More examples from the 14-page PQIiA can be found in the following pages.

RECENT PQIs IN ACTION

Below are a few of the more recent PQIiAs, highlighting current clinical priorities and emerging therapies:

▲ **Darolutamide (Nubeqa®)** — See above image and those in the following pages.

▲ **Enfortumab Vedotin-ejfv (Padcev®) + Pembrolizumab (Keytruda®)** — Management for Advanced or Metastatic Urothelial Carcinoma — Explores multidisciplinary coordination, patient selection, adverse event monitoring and collaborative process improvements that

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PQI IN ACTION

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teams implemented based on the PQI's framework.

▲ **Nirogacestat (Ogsiveo™)** — Management in Adults with Progressive Desmoid Tumors — Demonstrates how teams use quality standards to integrate this newer targeted therapy into practice, including patient monitoring and documentation strategies.

▲ **Siltuximab (Sylvant®)** — PQIiA for Idiopathic Multicentric Castleman Disease — Highlights real-world application of treatment management principles, toxicity monitoring and multidisciplinary coordination across comprehensive oncology teams.

▲ **Pacritinib (Vonjo®)** — Cytopenic Myelofibrosis Implementation — Describes how medically integrated teams operationalize symptom prioritization, therapy monitoring and collaborative follow-up care.

▲ **Proactive Symptom Management in Myelofibrosis** — Focuses on symptom assessment, practical toxicity mitigation strategies and team roles in ongoing support.

▲ **Medically Integrated Dispensing of Regorafenib (Stivarga®)** — Metastatic Colorectal Cancer — Case example showing how a PQI helps standardize clinical pharmacy integration, dosing workflows and multidisciplinary communication at large oncology organizations.

▲ **Ixazomib (Ninlaro®)** — Multiple Myeloma PQIiA — Offers insight on how practices implement key management steps from the underlying PQI, including patient selection, dosing considerations and coordination of monitoring.

▲ **Zanubrutinib (Brukhinsa®)**— Mantle Cell Lymphoma Patient Selection and Management — Illustrates how teams operationalize clinical criteria, patient education and monitoring pathways embedded in the PQI.

Each PQIiA reinforces a central theme: quality oncology care depends not only on selecting the appropriate therapy but also on building reliable systems that support patients throughout treatment.

STRENGTHENING THE MULTIDISCIPLINARY MODEL

PQIiAs consistently demonstrate the value of medically integrated oncology practices. By embedding pharmacy services within the clinical setting and aligning quality standards with patient outcomes, these models strengthen communication, reduce delays and enhance adherence.

Across topics — from biomarker testing to toxicity management — PQIiAs reflect the daily coordination required among prescribers, pharmacists, nurses and administrative teams. They illustrate how quality standards can be woven into documentation practices, prior authorization workflows,

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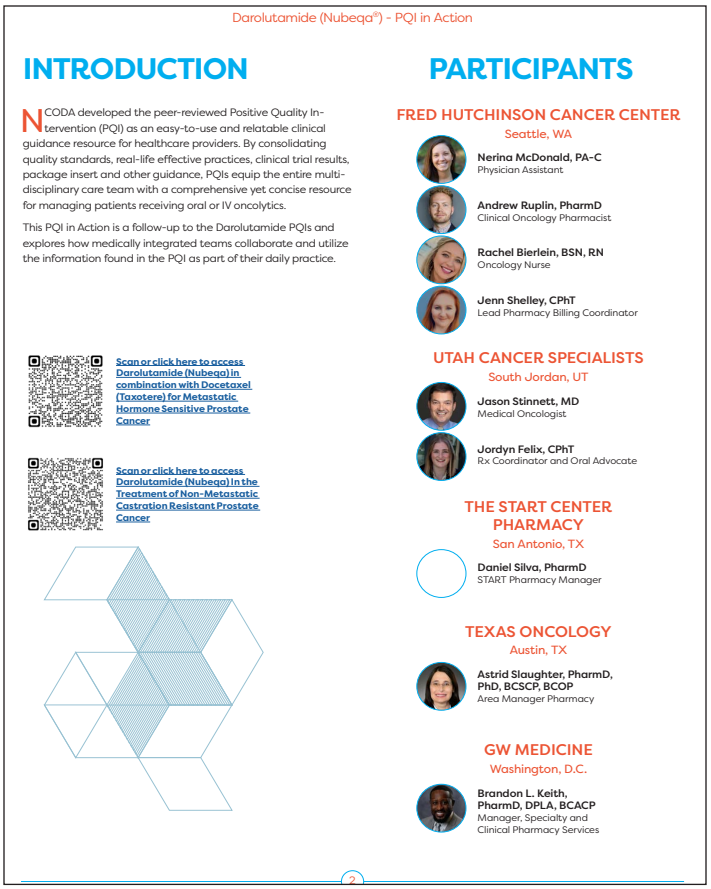

Darolutamide (Nubeqa®) - PQI in Action

INTRODUCTION

NCODA developed the peer-reviewed Positive Quality Intervention (PQI) as an easy-to-use and relatable clinical guidance resource for healthcare providers. By consolidating quality standards, real-life effective practices, clinical trial results, package insert and other guidance, PQIs equip the entire multidisciplinary care team with a comprehensive yet concise resource for managing patients receiving oral or IV oncolytics.

This PQI in Action is a follow-up to the Darolutamide PQIs and explores how medically integrated teams collaborate and utilize the information found in the PQI as part of their daily practice.

Scan or click here to access Darolutamide (Nubeqa) in combination with Docetaxel (Taxotere) for Metastatic Hormone Sensitive Prostate Cancer

Scan or click here to access Darolutamide (Nubeqa) in the Treatment of Non-Metastatic Castration Resistant Prostate Cancer

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CLINICAL BACKGROUND: DAROLUTAMIDE (NUBEQA®)

Prostate cancer leads as the most common cancer and the second leading cause of cancer death in men in the United States.[1] In addition, marked racial and ethnic disparities persist in prostate cancer incidence and outcomes. Black men have the highest incidence rate of prostate cancer (191.5 per 100,000), which is 67% higher than White men and nearly double that of American Indian/Alaska Native and Hispanic men. They are also diagnosed at a younger median age and have higher incidence across every age group. The causes of these disparities are multifactorial and are thought to include a complex interplay of genetic, environmental, and social determinants of health.[1]

Given the significant disease burden and the importance of optimizing outcomes across diverse patient populations, effective management strategies for prostate cancer remain a key clinical priority. Darolutamide, an androgen receptor inhibitor, offers an important therapeutic option for patients with non-metastatic and metastatic castration-resistant prostate cancer, as well as metastatic hormone-sensitive prostate cancer.

Darolutamide is indicated for the treatment of adult patients with[2]:

- non-metastatic castration-resistant prostate cancer (nmCRPC)
- metastatic castration-sensitive prostate cancer (mCSPC). *(approved in June 2025)*
- metastatic castration-sensitive prostate cancer (mCSPC) in combination with docetaxel

In clinical trials, the most common adverse reactions associated with darolutamide varied by indication. In patients with nmCRPC and mCSPC, the most frequent adverse reactions (greater than 10% and at least 2% more common than with placebo), including laboratory test abnormalities, were increased aspartate aminotransferase (AST), decreased neutrophil count, increased bilirubin, fatigue, and increased alanine aminotransferase (ALT). In patients with mCSPC receiving darolutamide in combination with docetaxel, the most common adverse reactions (10% or more and at least 2% greater than with placebo) were constipation, rash, decreased appetite, hemorrhage, increased weight, and hypertension.

The most frequent laboratory abnormalities (30% or more) included anemia, hyperglycemia, decreased lymphocyte and neutrophil counts, increased AST and ALT, and hypocalcemia.[2] The recommended darolutamide dose is 600 mg (two 300 mg tablets) taken orally, twice daily, with food.[2]

HCP INSIGHTS: PATIENT SELECTION, ACCESS CONSIDERATIONS, AND THE IMPACT OF THE EXPANDED DAROLUTAMIDE INDICATION

Clinicians emphasized that patient selection for darolutamide is guided primarily by indication, comorbidities, drug interactions, and the overall safety profile of the medication. Jason Stinnett, MD, medical oncologist at Utah Cancer Specialists, underscored that prescribing remains aligned with approved indications but noted that payer formularies still shape treatment choices. "Insurance may still dictate a preferred formulary product per their own pharmacy benefit manager," he explained. Dr. Stinnett added that darolutamide can offer advantages for patients with diabetes because "abiraterone requires concomitant glucocorticoid use," which may complicate glycemic control.

Advanced practice providers described similar considerations. Nerina McDonald, PA-C, shared that their team at Fred Hutch evaluates a patient's comorbidities, performance status, and potential drug interactions when determining whether darolutamide is appropriate. "We rely a lot on concomitant medical conditions and how fit patients are," she said. Because darolutamide is generally well tolerated, the team "has not run into a lot of issues," although interactions with statins are monitored closely and are typically "easy to adjust."

Positive Quality Intervention in Action

PQI IN ACTION

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patient education materials and follow-up protocols.

Importantly, PQIiAs also serve as advocacy tools. By documenting how evidence-based care is delivered in real-world oncology settings, they provide policymakers, payers and stakeholders with insight into the operational realities of cancer care. This transparency reinforces the need for policies that support timely access, clinical autonomy and patient-centered outcomes.

A LIVING QUALITY LIBRARY

As oncology care continues to evolve — with new therapies, complex monitoring requirements and emerging value-based models — the PQI and PQIiA library grows alongside it. Each addition represents collaboration among experts committed to advancing consistent, high-quality care across diverse practice settings.

Together, PQIs and PQIiAs translate standards into action. They empower oncology teams to reduce variability, improve coordination and maintain a focus on measurable patient outcomes. By grounding guidance in real-world experience, NCODA continues to build a practical, peer-driven quality framework that supports excellence across the oncology continuum.

HCP Insights: Patient Selection, Access Considerations, and the Impact of the Expanded Darolutamide Indication - continued

CLINICAL PERSPECTIVE ON THE EXPANDED INDICATION

The recent (June, 2025) expanded indication for darolutamide in mCSPC has been well received by clinicians and pharmacists who had already incorporated the agent into practice. Andrew Ruplin, PharmD, described the latest approval as confirmation of what many teams were already doing. "The pivotal trial revealed something we were not surprised about," he said. "An androgen receptor inhibitor would work quite well in the metastatic castrate-sensitive setting." He added that darolutamide's safety features, including a lower potential for interactions and lower blood-brain barrier penetration, have provided advantages for patients who experienced fatigue or neurocognitive side effects with other agents.

Dr. Stinnett highlighted new evidence supporting the expanded indication. He referenced the ARANOTE trial, a randomized phase III study showing that darolutamide plus androgen deprivation therapy (ADT) significantly improved radiographic progression free survival compared to ADT alone. "This was observed in both high volume and lower volume disease without a meaningful increase in side effects," he explained. In the treatment group, the median time to radiographic progression was not reached, compared to 25 months in the ADT-only group. Dr. Stinnett added, "It gives those of us who treat prostate cancer an additional option for our patients." He shared that he has used darolutamide in triplet therapy with excellent tolerance and long-standing benefit, and that the broadened approval gives an additional indication for patients.

Ruplin echoed that the expanded indication aligns with clinical practice patterns. The update helps ensure "affordable coverage" for patients, particularly those who were previously receiving darolutamide off-label due to drug interaction concerns with other agents. He explained that while the approval does not change management for patients who are already chemotherapy candidates, it "opened up additional opportunities" for patients who are not eligible for docetaxel.

McDonald added that as familiarity with the drug has increased, so has its use across a wider range of clinical presentations. "We are expanding the treatment and applying it to more patients," she said. Their team is now using darolutamide in mCSPC with docetaxel upfront, as well as in nmCRPC, reflecting the growing comfort and experience within the multidisciplinary team. Collectively, these insights highlight how clinicians across roles are incorporating darolutamide more broadly, balancing patient-level considerations with payer dynamics, and leveraging new evidence to support informed, individualized treatment decisions.

THE VALUE OF THE MEDICALLY INTEGRATED PHARMACY AND THE ONCOLOGY CARE TEAM

The implementation of Medically Integrated Pharmacy (MIP) practices within oncology care has transformed how patients experience and manage complex treatment regimens. With a growing emphasis on collaborative, patient-centered care, MIP structures aim to streamline communication, enhance medication safety, and improve treatment adherence, resulting in improvements across clinical outcomes. A defining strength of MIP is its multidisciplinary nature, where physicians, pharmacists, nurses, advanced practice providers, financial advocates, and pharmacy technicians work together to provide coordinated and comprehensive support.

The importance of this model is reinforced in the ASCO/NCODA Patient-Centered Standards for Medically Integrated Oncology Practices, which outline best practices that advance safety, efficiency, and equity in cancer care. These standards highlight key elements such as integrated clinical and pharmacy communication, proac-

The Value of the Medically Integrated Pharmacy and the Oncology Care Team - continued

tive toxicity management, consistent patient education processes, financial navigation, and ongoing quality improvement activities that center the needs and experiences of each patient. By embedding pharmacy services directly within the oncology clinic, teams can respond more efficiently to clinical changes, address barriers to medication access, and maintain continuity throughout the treatment journey.[3]

For patients receiving therapies like darolutamide, the MIP model supports timely initiation, close monitoring of laboratory parameters, management of treatment-related adverse effects, and adherence counseling. The collaborative structure ensures that every member of the care team contributes to a unified approach that enhances safety, improves quality of life, and supports optimal outcomes.

TEAM INSIGHTS ON THE VALUE OF THE MEDICALLY INTEGRATED PHARMACY

Insights from care team members illustrate how the medically integrated pharmacy (MIP) model strengthens coordination, enhances safety, and improves the overall patient experience during darolutamide therapy.

Dr. Stinnett described the meaningful impact the MIP structure has on patient care within his practice. He shared that his team has "seen a notable improvement in compliance and general patient understanding of their treatment and disease process as a result of our integrated pharmacy." He emphasized the coordinated roles across the care team, noting the value of dedicated nurse managers who maintain regular communication with patients and relay concerns promptly. He also highlighted the pharmacy team's essential contributions, including securing financial assistance, ensuring timely refills, and screening for drug interactions in "an older population who often have polypharmacy concerns."

Brandon L. Keith, PharmD, DPLA, BCACP, Manager of Specialty and Clinical Pharmacy Services at GW Medicine, emphasized the importance of multidisciplinary teamwork in delivering well-rounded care. He noted, "It is important to have the perspectives of various team members. We all have different training and experience, and as pharmacists we are the medication experts." He also underscored the operational value of MIP structures, explaining that the specialty pharmacy team manages prior authorizations, billing, and patient assistance programs while maintaining direct communication with prescribers and patients. "All this communication can be tracked within the patient's EMR," he said, which supports efficiency and care continuity.

From the perspective of McDonald, close communication between pharmacy, nursing, and advanced practice providers is critical for maintaining patient safety. She shared that regular check-ins and collaborative adherence to safety guidelines ensure that patients are monitored proactively throughout their treatment course.

Jordyn Felix, CPhT a pharmacy technician at Utah Cancer Specialists, highlighted how the integrated approach enhances medication safety and reduces communication gaps. "The value of our team is definitely the comprehensive patient care," she said. "When we all work together, our model reduces communication gaps between the providers and the pharmacy while also improving medication safety for our patients."

> "When we all work together, our model reduces communication gaps between the providers and the pharmacy while also improving medication safety for our patients."
>
> Jordyn Felix, CPhT.

TEAM ROLES IN MEDICALLY INTEGRATED PROSTATE CANCER CARE

The management of prostate cancer, including therapies such as darolutamide, relies heavily on the coordinated efforts of a medically integrated oncology team. Each member contributes unique expertise to ensure patients receive safe, timely, and comprehensive care. Through interviews with physicians, pharmacists, pharmacy technicians, nurses, and advanced practice providers, a consistent theme emerged: streamlined communication, shared responsibility, and integrated workflows lead to better patient experiences and improved treatment access. The following sections highlight the distinct and complementary roles within the medically integrated pharmacy model.

PHYSICIAN AND ADVANCED PRACTICE PROVIDERS

Physicians and advanced practice providers (APPs) play a central role in directing treatment decisions, assessing patient readiness for therapy, and managing symptoms throughout the course of care. Their clinical oversight ensures that therapies such as darolutamide are used appropriately and safely within the broader treatment landscape of prostate cancer.

At Utah Cancer Specialists, Dr. Stinnett provides comprehensive hematology and oncology care, treating a broad mix of patients with both malignant and benign conditions. Prostate cancer represents one of the most common diagnoses in his practice, second only to breast cancer. In addition to his clinical responsibilities, he dedicates a portion of his time to administrative duties, but his primary focus remains direct patient care.

Advanced Practice Providers (APPs) support treatment decisions, symptom management, and ongoing assessment of patients receiving therapies such as darolutamide. McDonald cares primarily for patients with prostate cancer, urothelial carcinoma, and testicular cancer. She noted that her work involves close collaboration with pharmacy and nursing to ensure patients start therapy safely, remain adherent, and receive timely monitoring.

PHARMACISTS

Pharmacists are the medication experts within the medically integrated pharmacy model and provide critical oversight for oral and IV anticancer treatments. Ruplin shared that he serves as "the medication expert for our entire medical oncology team in the GU clinic." His responsibilities include reviewing antineoplastic orders, evaluating supportive medications, managing comorbid conditions such as hypertension, and conducting in-depth patient education on oral prostate cancer therapies.

McDonald emphasized the team's reliance on pharmacists when patients begin therapies such as darolutamide. She shared that pharmacists "take a thorough look at their other medications and let us know if there are any red flags or things that should be addressed or adjusted." Keith oversees a team of pharmacists, pharmacy technicians, and pre-certification staff. His role includes maintaining accreditation, managing relationships with payers and manufacturers, overseeing operational performance, and ensuring coordination "from the beginning when treatment is initiated to dispensing, monitoring, follow-up, and refills."

At Texas Oncology, Astrid Slaughter, PharmD, PhD, BCSCP, BCOP ensures that every regimen aligns with guidelines and reviews both IV and oral therapies for safety and appropriateness. She noted that as nursing workload has increased, pharmacy is likely to take the lead in chemotherapy education because "we are geared toward patient education based on our training."

Daniel Silva, PharmD, from the START Center, emphasized operational leadership in the outpatient medically integrated pharmacy. His responsibilities include maintaining workflow efficiency, resolving process challenges, supporting technicians and pharmacists, and ensuring patients receive timely access to oral oncology therapies.

NURSING

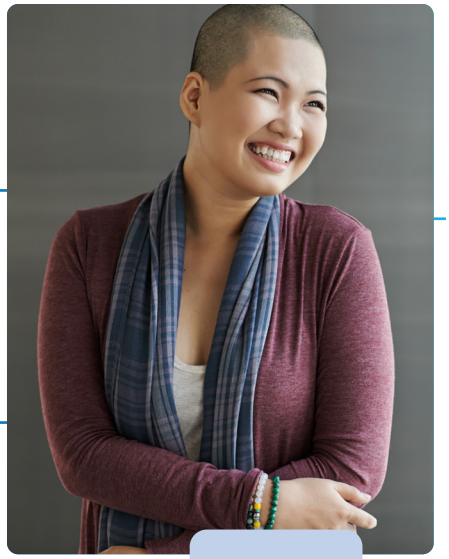
Nurses are essential to patient education, symptom monitoring, and day-to-day support throughout prostate cancer treatment. Rachel Bierlein, BSN, RN, a clinical nurse coordinator in the Genitourinary Oncology department at Fred Hutch, described nursing as "really patient education, symptom management, and supporting patients from their first visit and throughout their entire treatment journey."

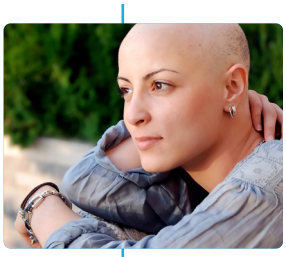
Because patients have direct access to the nursing line, they consistently reach the same team, which creates continuity and builds strong, trusting relationships. Nurses coordinate pre-education steps, follow-up plans, and ensure that patients are connected with financial services when cost concerns arise. Ruplin added that nurses play a critical educational role, noting that "I cannot do every single educational session, and my nurses help by doing the intravenous chemotherapy education."

McDonald emphasized that nurses are "pivotal to making sure that patients

Patient Education Sheets

Cancer care, explained.





NEW name, *SAME TRUSTED* guidance.

The Oral Chemotherapy Education (OCE) and Intravenous Cancer Treatment Education (IVE) sheets are now known as **Patient Education Sheets** (**PES**) - a clearer, more consistent name for the same expert-backed resources you rely on.

For years, clinicians and patients alike have turned to these sheets for straightforward, evidence-based guidance. Now, our redesigned platform offers faster, more intuitive access with enhanced search functionality to make finding information easier than ever.

This collaborative initiative draws upon the clinical expertise of ACCC, HOPA, NCODA, and ONS, ensuring each Patient Education Sheet remains accurate, comprehensive, and reflective of best practices in cancer care.

Explore the new platform and discover a modern experience built to support patients and providers alike.

www.PatientEducationSheets.com

Brought to you by: ACCC Association of Cancer Care Centers™ · HOPA Hematology/Oncology Pharmacy Association · NCODA Network for Collaborative Oncology Development & Advancement · ONS Oncology Nursing Society

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PATIENT EDUCATION SHEETS: SUPPORTING PATIENTS THROUGH THEIR CANCER JOURNEY

Patient Education Sheets (PES) are evidence-based, patient-friendly guides created to help people with cancer and their caregivers understand treatment plans, what to expect, and how to manage side effects.

Each sheet explains how a therapy works, how it is administered, potential side effects and practical tips for self-care. They often include space for clinicians to add counseling notes or local contact information.

By distilling complex oncology treatment information into straightforward language at a fifth- to eighth-grade reading level, PES help reduce anxiety, strengthen understanding and support adherence throughout the cancer care journey.

For more information about **Patient Education Sheets**, scan the QR code above.

PES grew from NCODA's well-known Oral Chemotherapy Education (OCE) and Intravenous Cancer Treatment Education (IVE) platforms into a unified, searchable online library that now offers more than 300 downloadable sheets covering oral, injectable and infusion therapies, symptom management and general cancer care topics.

The resource is widely used by oncology teams and patients — accessed by healthcare providers more than 200,000 times each month — reflecting its value as a trusted educational tool.

Intended to supplement in-clinic counseling, PES can be downloaded and printed for distribution during patient visits. They reinforce verbal education with a reliable takeaway reference that patients and caregivers can revisit at home, improving communication and helping ensure patients leave appointments feeling empowered, informed and prepared to manage treatment.

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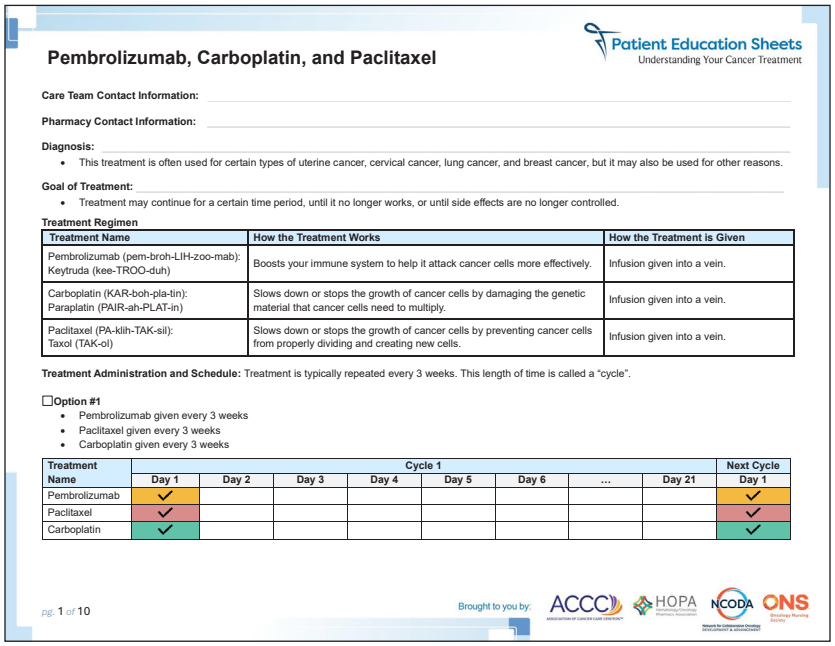

Patient Education Sheets
Understanding Your Cancer Treatment

Pembrolizumab, Carboplatin, and Paclitaxel

Care Team Contact Information: _____

Pharmacy Contact Information: _____

Diagnosis: _____
- This treatment is often used for certain types of uterine cancer, cervical cancer, lung cancer, and breast cancer, but it may also be used for other reasons.

Goal of Treatment: _____
- Treatment may continue for a certain time period, until it no longer works, or until side effects are no longer controlled.

Treatment Regimen

Treatment Name	How the Treatment Works	How the Treatment is Given
Pembrolizumab (pem-broh-LIH-zoo-mab): Keytruda (kee-TROO-duh)	Boosts your immune system to help it attack cancer cells more effectively.	Infusion given into a vein.
Carboplatin (KAR-boh-pla-tin): Paraplatin (PAIR-ah-PLAT-in)	Slows down or stops the growth of cancer cells by damaging the genetic material that cancer cells need to multiply.	Infusion given into a vein.
Paclitaxel (PA-klih-TAK-sil): Taxol (TAK-ol)	Slows down or stops the growth of cancer cells by preventing cancer cells from properly dividing and creating new cells.	Infusion given into a vein.

Treatment Administration and Schedule: Treatment is typically repeated every 3 weeks. This length of time is called a "cycle".

☐**Option #1**
- Pembrolizumab given every 3 weeks
- Paclitaxel given every 3 weeks
- Carboplatin given every 3 weeks

Treatment Name	Cycle 1								Next Cycle
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	…	Day 21	Day 1
Pembrolizumab	✓								✓
Paclitaxel	✓								✓
Carboplatin	✓								✓

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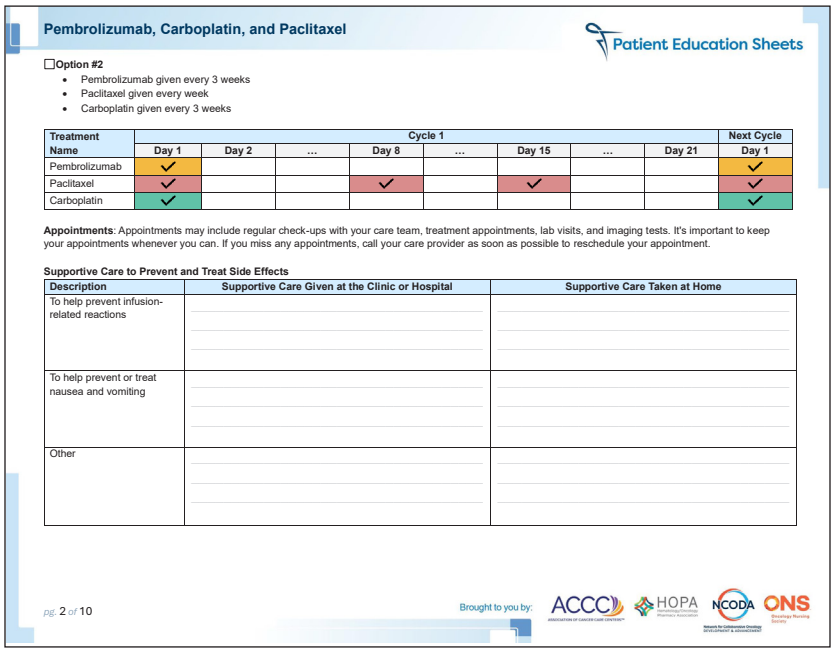

Pembrolizumab, Carboplatin, and Paclitaxel

Patient Education Sheets

☐**Option #2**
- Pembrolizumab given every 3 weeks
- Paclitaxel given every week
- Carboplatin given every 3 weeks

Treatment Name	Cycle 1								Next Cycle
	Day 1	Day 2	…	Day 8	…	Day 15	…	Day 21	Day 1
Pembrolizumab	✓								✓
Paclitaxel	✓			✓		✓			✓
Carboplatin	✓								✓

Appointments: Appointments may include regular check-ups with your care team, treatment appointments, lab visits, and imaging tests. It's important to keep your appointments whenever you can. If you miss any appointments, call your care provider as soon as possible to reschedule your appointment.

Supportive Care to Prevent and Treat Side Effects

Description	Supportive Care Given at the Clinic or Hospital	Supportive Care Taken at Home
To help prevent infusion-related reactions		
To help prevent or treat nausea and vomiting		
Other		

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These sample pages taken from a 10-page Patient Education Sheet on Pembrolizumab, Carboplatin and Paclitaxel provide clear, simple instructions and charts for the patient. More examples of the PES can be found on the following page.

PATIENT EDUCATION SHEETS

CONTINUED FROM PREVIOUS PAGE

Content for PES is developed and reviewed by a multidisciplinary committee of oncology professionals, drawing expertise from pharmacists, nurses, advanced practice providers and other clinicians.

Importantly, the initiative is a collaborative effort led by NCODA in partnership with the Association of Cancer Care Centers, the Hematology/Oncology Pharmacy Association and the Oncology Nursing Society. These founding partners provide clinical insight, ensure comprehensive content and uphold standards that support consistency and accuracy in patient education across settings.

RECENT PATIENT EDUCATION SHEETS

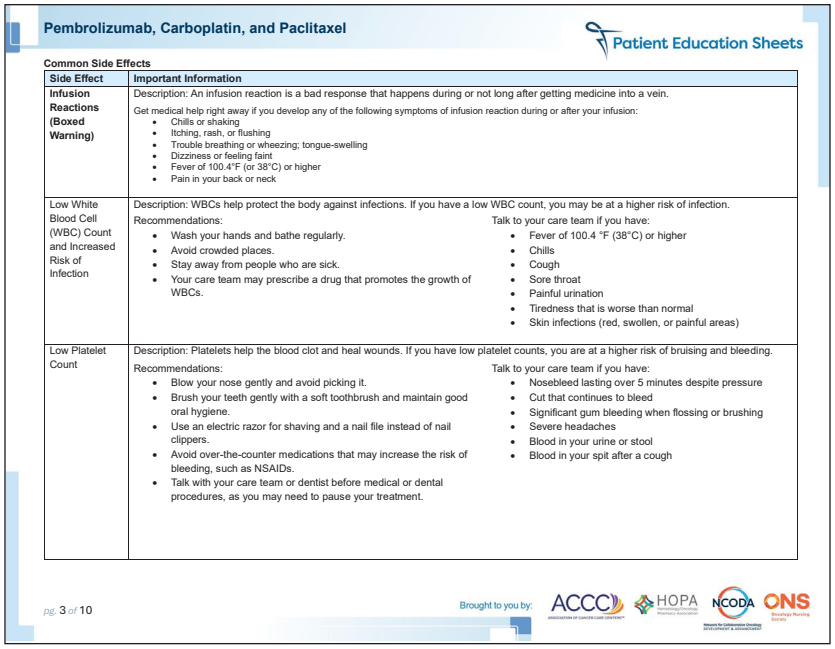
Below are 10 recently published or updated PES:

- **Zenocutuzumab**
- **Luspatercept**
- **Carboplatin and Etoposide**
- **Amivantamab and Lazertinib**
- **Understanding Hormonal Side Effects During Cancer Treatment**
- **Understanding Diarrhea During Cancer Treatment**
- **Understanding and Managing Treatment-Related Fatigue**
- **Teclistamab**
- **Trilaciclib**
- **Polatuzumab Vedotin, Rituximab, Cyclophosphamide, Doxorubicin and Prednisone**

INTEGRATING PES INTO CARE WORKFLOWS

Clinics and oncology practices are encouraged to integrate PES into routine education workflows — including pre-therapy initiation, during treatment planning and at follow-up visits — to ensure patients and caregivers have clear and accessible information. Because PES can be easily printed or electronically shared, they help standardize patient education across teams and support adherence by providing consistent messaging regardless of setting.

By offering practical, up-to-date education resources developed by leaders in oncology care and reviewed by multidisciplinary experts, Patient Education Sheets help bridge communication gaps, empower patients and caregivers with knowledge, and support oncology care teams in delivering informed, compassionate care.



Pembrolizumab, Carboplatin, and Paclitaxel

Patient Education Sheets

Common Side Effects

Side Effect	Important Information
Infusion Reactions (Boxed Warning)	Description: An infusion reaction is a bad response that happens during or not long after getting medicine into a vein. Get medical help right away if you develop any of the following symptoms of infusion reaction during or after your infusion: • Chills or shaking • Itching, rash, or flushing • Trouble breathing or wheezing; tongue-swelling • Dizziness or feeling faint • Fever of 100.4°F (or 38°C) or higher • Pain in your back or neck
Low White Blood Cell (WBC) Count and Increased Risk of Infection	Description: WBCs help protect the body against infections. If you have a low WBC count, you may be at a higher risk of infection. Recommendations: • Wash your hands and bathe regularly. • Avoid crowded places. • Stay away from people who are sick. • Your care team may prescribe a drug that promotes the growth of WBCs. Talk to your care team if you have: • Fever of 100.4 °F (38°C) or higher • Chills • Cough • Sore throat • Painful urination • Tiredness that is worse than normal • Skin infections (red, swollen, or painful areas)
Low Platelet Count	Description: Platelets help the blood clot and heal wounds. If you have low platelet counts, you are at a higher risk of bruising and bleeding. Recommendations: • Blow your nose gently and avoid picking it. • Brush your teeth gently with a soft toothbrush and maintain good oral hygiene. • Use an electric razor for shaving and a nail file instead of nail clippers. • Avoid over-the-counter medications that may increase the risk of bleeding, such as NSAIDs. • Talk with your care team or dentist before medical or dental procedures, as you may need to pause your treatment. Talk to your care team if you have: • Nosebleed lasting over 5 minutes despite pressure • Cut that continues to bleed • Significant gum bleeding when flossing or brushing • Severe headaches • Blood in your urine or stool • Blood in your spit after a cough

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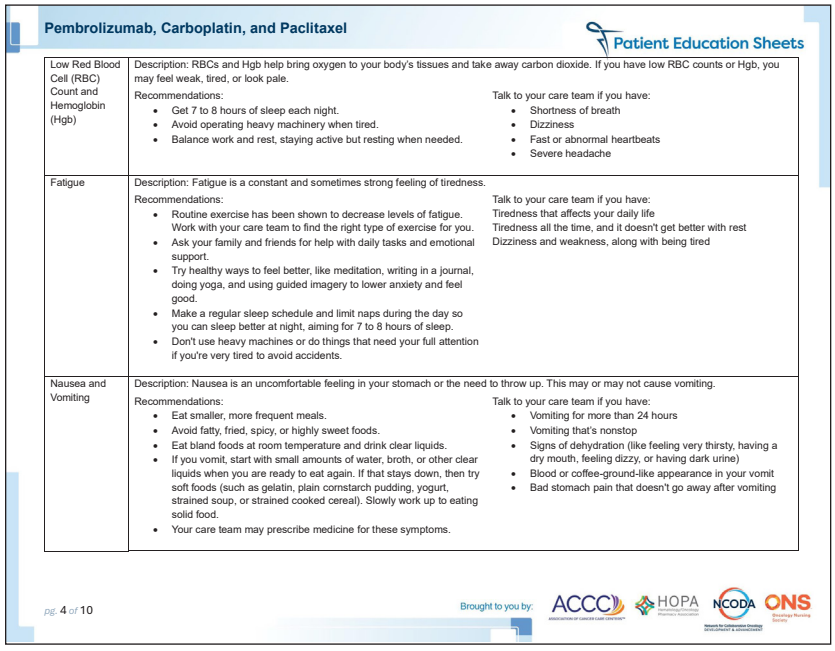

Pembrolizumab, Carboplatin, and Paclitaxel

Patient Education Sheets

Low Red Blood Cell (RBC) Count and Hemoglobin (Hgb)	Description: RBCs and Hgb help bring oxygen to your body's tissues and take away carbon dioxide. If you have low RBC counts or Hgb, you may feel weak, tired, or look pale. Recommendations: • Get 7 to 8 hours of sleep each night. • Avoid operating heavy machinery when tired. • Balance work and rest, staying active but resting when needed. Talk to your care team if you have: • Shortness of breath • Dizziness • Fast or abnormal heartbeats • Severe headache
Fatigue	Description: Fatigue is a constant and sometimes strong feeling of tiredness. Recommendations: • Routine exercise has been shown to decrease levels of fatigue. Work with your care team to find the right type of exercise for you. • Ask your family and friends for help with daily tasks and emotional support. • Try healthy ways to feel better, like meditation, writing in a journal, doing yoga, and using guided imagery to lower anxiety and feel good. • Make a regular sleep schedule and limit naps during the day so you can sleep better at night, aiming for 7 to 8 hours of sleep. • Don't use heavy machines or do things that need your full attention if you're very tired to avoid accidents. Talk to your care team if you have: Tiredness that affects your daily life Tiredness all the time, and it doesn't get better with rest Dizziness and weakness, along with being tired
Nausea and Vomiting	Description: Nausea is an uncomfortable feeling in your stomach or the need to throw up. This may or may not cause vomiting. Recommendations: • Eat smaller, more frequent meals. • Avoid fatty, fried, spicy, or highly sweet foods. • Eat bland foods at room temperature and drink clear liquids. • If you vomit, start with small amounts of water, broth, or other clear liquids when you are ready to eat again. If that stays down, then try soft foods (such as gelatin, plain cornstarch pudding, yogurt, strained soup, or strained cooked cereal). Slowly work up to eating solid food. • Your care team may prescribe medicine for these symptoms. Talk to your care team if you have: • Vomiting for more than 24 hours • Vomiting that's nonstop • Signs of dehydration (like feeling very thirsty, having a dry mouth, feeling dizzy, or having dark urine) • Blood or coffee-ground-like appearance in your vomit • Bad stomach pain that doesn't go away after vomiting

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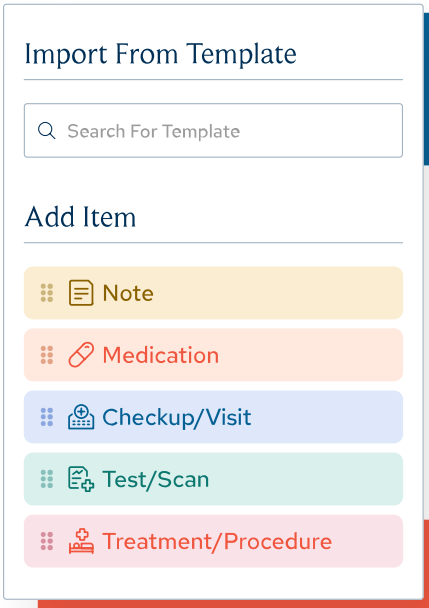
By offering practical, up-to-date education resources developed by leaders in oncology care and reviewed by multidisciplinary experts, Patient Education Sheets help bridge communication gaps, empower patients and caregivers with knowledge, and support oncology care teams in delivering informed, compassionate care.

Bring Clarity to Every Treatment Journey.

Introducing NCODA **Patient Treatment Calendars**

NCODA Patient Treatment Calendars help you turn detailed treatment plans into clear, personalized schedules patients and families can easily follow. Built with clinicians in mind, this trusted resource makes it simple to organize treatments, appointments, and key milestones into one structured, easy-to-understand calendar.



FOR PROVIDERS:
Create. Customize. Share.

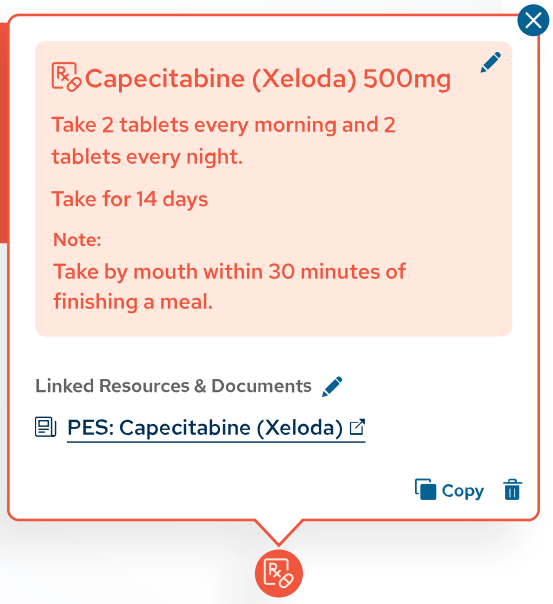
- Build calendars quickly using ready-to-use templates
- Personalize schedules to reflect each patient's care plan
- Securely share with patients and families
- Reduce administrative workload and save valuable time

Support patient understanding without adding to your workflow.

FOR PATIENTS:
Clear Plans. Greater Confidence.

- Simple, easy-to-read format
- Treatments, appointments, and milestones in one place
- Mobile-friendly access through secure links and QR codes
- Available anytime, anywhere

When patients can clearly see what's ahead, they feel more confident moving forward.



Personalized. Practical. Patient-Focused.

Whether you select an existing template or create a new calendar tailored to your practice, NCODA Patient Treatment Calendars provide an efficient way to deliver organized, individualized care timelines.

Explore the resource today: ***PatientTreatmentCalendars.com***

STAY UP-TO-DATE WITH THE LATEST ONCOLOGY INSIGHTS THROUGH NCODA WEBINARS

Explore NCODA's growing library of educational webinars designed to keep you informed, connected, and ahead in the evolving world of oncology care. Whether you're looking for the latest updates on clinical practice, policy developments or operational strategies, NCODA webinars deliver practical insights from leading experts and frontline practitioners.

Browse upcoming live sessions or access NCODA's archive of recorded content—anytime, anywhere. Use the keyword search to quickly locate topics most relevant to your role and patient population.

NCODA webinars are built for oncology professionals who value education that is both immediately applicable and strategically forward-looking. Each session brings together multidisciplinary perspectives — pharmacists, advanced practice providers, nurses, administrators, and policy experts — translating evidence, real-world experience and operational best practices into actionable guidance.

With rapid advancements in targeted therapies, biomarker-driven treatment decisions, reimbursement changes, and care coordination models, these webinars help your team remain confident, current and clinically agile.

LATEST WEBINARS

▲ **Pharmacy Perspectives: Lifestyle Strategies & CTCAE Updates** Featuring Sonia Thomas, PharmD, BCOP, and Ming-Hei Tai, PharmD, BCOP. A practical discussion on integrating lifestyle modification strategies alongside Common Terminology Criteria for Adverse Events-aligned toxicity assessments to strengthen patient management and outcomes.

▲ **Students Talk: Q&A, Feedback, and Fresh Ideas** Featuring Mustafa Abacioglu, MS, Faculty of Pharmacy. An interactive forum highlighting student insights and fresh perspectives to support innovation in oncology practice.

▲ **Minimizing Toxicity from Amivantamab & Lazertinib** Featuring Jorge J. Nieva, MD. Clinical strategies for proactive toxicity monitoring and management when using these targeted therapies.

▲ **CE Opportunity: Educational & Equity Implications of Biomarker Testing & Targeted Therapy Access in NSCLC** Featuring Shawnny Eugene, PharmD, MBA, MS. Continuing education on biomarker-driven care, access challenges, and strategies to advance equitable testing and treatment pathways.

▲ **CE Opportunity: Nurses Talk Expanding Eligibility + Improving Outcomes in Allogeneic HCT** Featuring Katherine Hickey, AGACNP-BC. Continuing education exploring eligibility expansion and outcome optimization in allogeneic hematopoietic cell transplantation.

▲ **Techs Talk: Reducing Delays in Outpatient Oncology Pharmacy** Featuring Maddy Floysand, PharmD, and Shawnny Eugene, PharmD, MBA, MS. Operational strategies to streamline workflow and minimize treatment delays in outpatient oncology settings.

▲ **A Combination Treatment for Patients with Advanced Renal Cell Carcinoma** Featuring Brittney Carden, PharmD. An evidence-based overview of combination regimens in advanced RCC and practical implementation considerations.

For more information about **NCODA Webinars**, and links to archived content, scan the QR code above.

RECENT ON-DEMAND & ARCHIVED WEBINARS

NCODA's extensive archive provides ongoing access to high-value sessions from 2025 and beyond:

▲ **Navigating the Course of Oral Anticancer Medications: An Interprofessional Approach** A CE session focused on oral oncolytic coordination, adherence, and collaborative management strategies.

▲ **October 2025 International Monthly Webinar: Oncology Care Essentials** Coverage of Medicare updates, clinical tools, and DPYD testing considerations.

▲ **November 2025 International Monthly Webinar: Preparing for 2026** Insights into legislative trends, access innovation, and pricing changes impacting oncology practice.

▲ **NCODA Connect & GU Navigation in Action** A community-focused session exploring nurse navigation and member platform engagement.

WHY NCODA WEBINARS MATTERS FOR ONCOLOGY PROFESSIONALS

NCODA webinars are more than presentations. They are structured professional development experiences grounded in clinical evidence and operational reality. Many sessions offer continuing education credit, supporting certification maintenance while deepening clinical expertise. Just as importantly, they foster peer connection, shared problem-solving and alignment across multidisciplinary teams.

Whether you participate live to engage with faculty or access recordings on demand, NCODA's webinar library empowers your practice to adopt proven strategies, anticipate system-level changes, and integrate emerging science into patient-centered care.

NCODA PUBLICATIONS: INFORMING, CONNECTING AND ADVANCING ONCOLOGY PRACTICE

NCODA's publications extend our mission beyond meetings and online education, creating platforms that inform, connect and elevate the oncology community year-round.

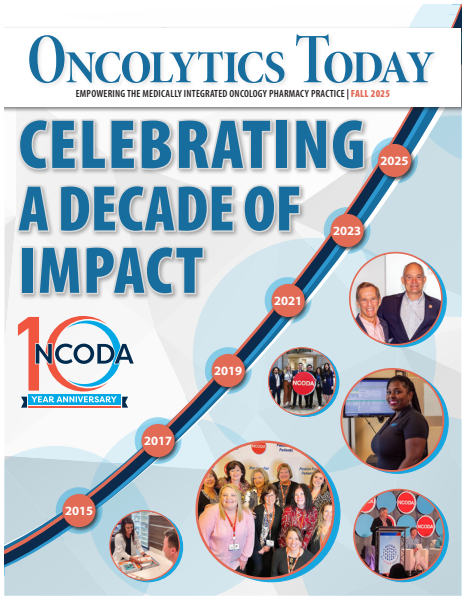
Together, ***Oncolytics Today***, ***SummitRewind***, ***ForumRewind*** and ***Inspire*** reflect the depth of expertise within medically integrated practices and the continued growth of NCODA's membership and professional reach.

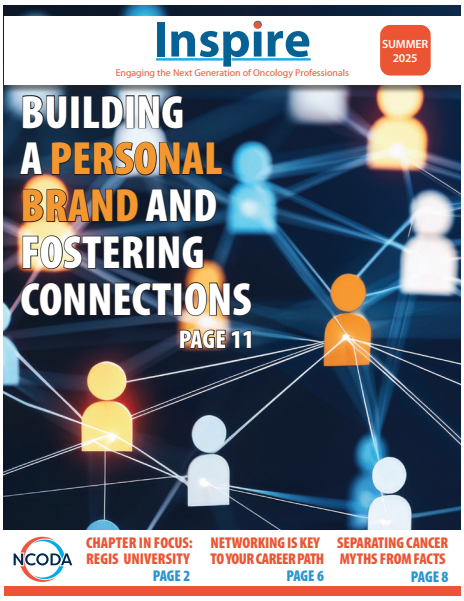
Oncolytics Today is NCODA's flagship publication and the cornerstone of its communications platform. With circulation expanding alongside membership growth, it reaches a broad and increasingly international audience.

The publication features original contributions from oncology pharmacists, physicians, advanced practice providers, nurses, administrators and policy leaders worldwide. Articles address clinical innovation, operational strategy, reimbursement and regulatory developments, advocacy priorities and real-world implementation models.

Oncolytics Today has become a respected forum for multidisciplinary thought leadership, helping shape conversations around high-quality cancer care. Its growing contributor base and readership underscore its role as NCODA's most visible and influential publication.

SummitRewind and ***ForumRewind*** capture key insights and practical takeaways from NCODA's live educational events, distilling presentations and panel discussions into concise, practice-focused summaries. The Rewinds allow attendees to revisit high-impact sessions and provide those unable to attend with accessible highlights, extending the impact of Summit and Forum throughout the year.





Inspire is NCODA's digital publication for Professional Student Organization leaders and students exploring oncology practice. Focused on professional development and peer engagement, it highlights emerging voices while reinforcing the principles of medically integrated care.

Together, these publications strengthen professional connection and ensure that innovation and shared experience remain accessible as the NCODA community continues to grow.

Where Innovation *Meets Evidence*

The **NCODA Oncology and Hematology Meeting Abstracts (NOHMA)** features newly submitted research, quality initiatives, and real-world oncology insights—now available to attendees before each meeting. Review the latest findings in advance, come prepared for deeper discussions, and engage with the evidence shaping medically integrated oncology practice.

NCODA Oncology & Hematology Meeting Abstracts (NOHMA)

Explore the Latest Research Before the Meeting Begins

NCODA

MM+M Awards 2024 Finalist

THE PQI PODCAST

The PQI Podcast, presented by NCODA, hosts clinical and administrative experts in oncology providing insight on important industry topics and how they value the Positive Quality Intervention (PQI) resource for their practice. The podcast also highlights patient stories of hope, determination, and how patient-centered care impacts the cancer journey.

STREAMING NOW

Listen & follow along!

NCODA

NCODA TREATMENT SUPPORT KITS

Bridging the Gap Between Treatment & Total Patient Care

When a patient begins a new cancer therapy, they need more than just a prescription—they need support. Every TSK is thoughtfully customized for specific oral oncology therapies and includes:

- **PATIENT-FRIENDLY EDUCATION**

  Clear, concise treatment guides to help patients understand what to expect and how to stay on track.

- **SUPPORTIVE CARE PRODUCTS**

  Therapy-specific over-the-counter items that proactively address common side effects—like nausea, mouth sores, or skin irritation.

- **ADHERENCE TOOLS**

  Creative, easy-to-use resources that empower patients to manage their medications and stay engaged in their care.

BUILT FOR CARE TEAMS, DESIGNED FOR PATIENTS

NCODA provides most TSKs at no cost to member practices, integrating them seamlessly into the clinical workflow. Every kit reinforces the critical relationship between the patient and their care team.

AVAILABLE KITS:

- abemaciclib
- abiraterone acetate
- bispecific
- cabozantinib
- capecitabine
- elranatamab
- fruquintinib
- inavolisib
- mirdametinib
- neratinib
- nirogacestat
- pacritinib
- tivozanib
- temozolomide

NCODA is a leading non-profit organization committed to enhancing patient-centered oncology care. Through collaboration, innovation, and the development of quality standards, NCODA supports medically integrated oncology teams in delivering exceptional treatment outcomes.

Join NCODA

Becoming a member of NCODA provides access to a wealth of resources, including TSKs, educational materials, and a network of oncology professionals dedicated to patient-centered care.

NCODA

BISPECIFIC T-CELL ENGAGERS (BTCEs) DIRECTORY

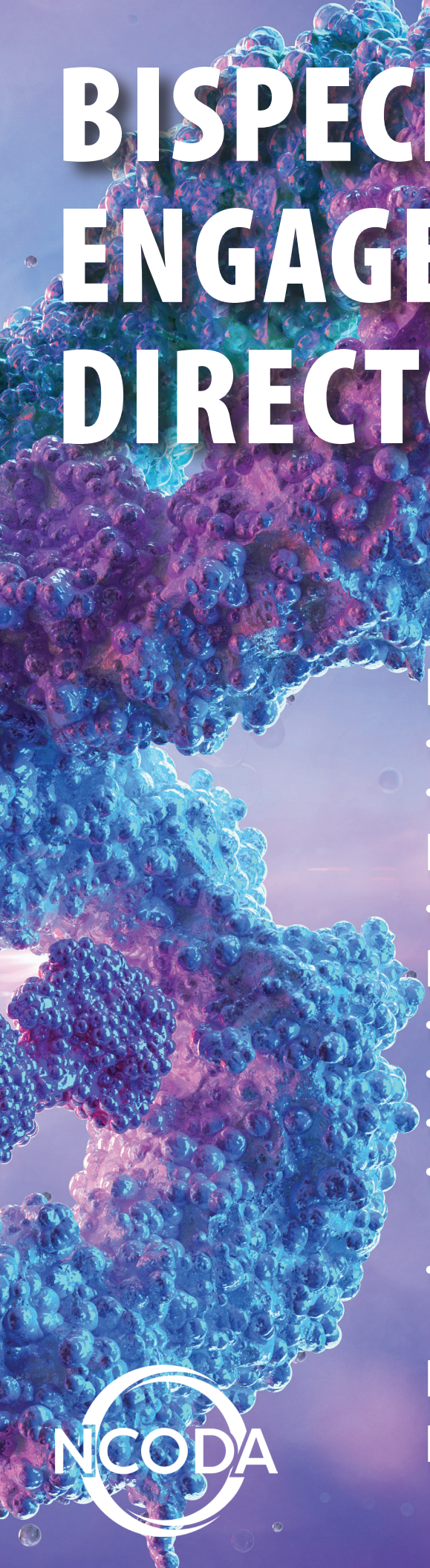


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TABLE 1: BTCEs IN LYMPHOMA (AS OF FEBRUARY 2026)

Drug	Mosunetuzumab-axgb (LUNSUMIO®, LUNSUMIO VELO™)[1–3]	Epcoritamab-bysp (EPKINLY®)[4,5]	Glofitamab-gxbm (COLUMVI™)[6,7]
Manufacturer	**Genentech, Inc.**	**AbbVie Inc. and Genmab US, Inc.**	**Genentech, Inc.**
Target	CD3xCD20	CD3xCD20	CD3xCD20
Indication(s)	FL following 2 or more lines of therapy	(1) LBCL following 2 or more lines of therapy (2) FL following 2 or more lines of therapy	DLBCL following 2 or more lines of therapy
Route of Administration	IV (LUNSUMIO®) or SC (LUNSUMIO VELO™)	SC	IV
Dosing Schedule	C1: Days 1, 8, 15 C2+: Day 1, every 21 d, for up to 8 cycles for patients achieving CR; for up to 17 cycles for patients achieving PR or SD	C1-3: Days 1, 8 ,15, and 22 C4-9: Days 1 and 15 C10+: Day 1, every 28 d until progression	C1: Obinutuzumab, Day 1; glofitamab Days 8 and 15 C2-12: Day 1, every 21 d
CRS Mitigation			
SUD Schedule	IV C1D1: 1 mg C1D8: 2 mg C1D15: 60 mg (FFD) SC C1D1: 5 mg C1D8: 45 mg (FFD) C1D15: 45 mg	LBCL C1D1: 0.16 mg C1D8: 0.8 mg C1D15: 48 mg (FFD) C1D22: 48 mg FL C1D1: 0.16 mg C1D8: 0.8 mg C1D15: 3 mg C1D22: 48 mg (FFD)	C1D1: Obinutuzumab 1,000 mg C1D8: 2.5 mg (first dose of glofitamab) C1D15: 10 mg C2D1+: 30 mg (FFD)
Premedications	(1) Acetaminophen 500–1,000 mg (2) Diphenhydramine 50–100 mg (or equivalent) (3) Dexamethasone 20 mg or methylprednisolone 80 mg Note: Premedications are recommended for IV mosunetuzumab during C1 and C2 and for SC administration during C1 only. Regardless of route of administration, any patient who experienced CRS of any grade with the previous dose should receive premedications prior to the next dose	(1) Acetaminophen 650–1,000 mg (2) Diphenhydramine 50 mg (or equivalent) (3) Dexamethasone 15 mg or prednisolone 100 mg (or equivalent), before C1 treatments and for 3 consecutive days after Continue dexamethasone thereafter if G2 or G3 CRS with prior dose	(1) Acetaminophen 500–1,000 mg (2) Diphenhydramine 50 mg (or equivalent) (3) Dexamethasone 20 mg (or equivalent) on C1D8, C1D15, C2D1, and C3D1. Continue if CRS occurs with prior dose
Hospitalization	Consider	LBCL: C1D15 (FFD): 24-h admission FL: Consider	C1D8: 24-h admission
CRS Incidence	G1: 26%; G2: 17%; G3: 1%; G4: 1%; G5: 0%	LBCL: G1 37%; G2 17%; G3 3%; G4–5 0% FL: G1 45%; G2 9%; G3 0%; G4–5 0%	G1: 47%; G2: 12%; G3: 3%; G4: 1%; G5: 0%
	Time course for CRS onset: C1D1: 23% C1D8: 6% C1D15: 36% C2D1: 10% C3+D1: 2% Median time to CRS onset: C1D1: 5 h C1D8: 20 h C1D15: 27 h C2D1: 38 h	Time course for CRS onset: C1D1: LBCL 6%, FL 12% C1D8: LBCL 12%, FL 6% C1D15: LBCL 43%, FL 15% C1D22: LBCL 5%, FL 37% Median time to CRS onset: After most recent dose: LBCL 24 h (range: 0–10 d), FL 59 h (range: 0.1–7 d) After FFD: LBCL 21 h (range: 0–7 d), FL 61 h (range: 0.1–7 d)	Time course for CRS onset: C1D8: 42% C1D15: 25% C2: 26% C3+: 1% Median time to CRS onset: C1D8: 14 h (range: 6–52 h)
Median Duration of CRS	3 d (range: 1–29 d)	2 d (range: 1–27 d)	30.5 h (range: 0.5–317 h)
ICANS Incidence	G1–2: 3%; G3–5: 0%	LBCL: G1 4.5%; G2 1.3%; G3–4 0%; G5 0.6% FL: G1 3.9%; G2 2.4%; G3–4 0%; G5 0%	G1–2: 5%; G3–4: 3%; G5: 0%

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ABBREVIATIONS: **ALL:** Acute Lymphoblastic Leukemia; **ALP:** alkaline phosphatase; **ALT:** Alanine Aminotransferase; **AST:** Aspartate Aminotransferase; **BCMA:** B-Cell Maturation Antigen; **BCP:** B-cell Precursor; **BTCE:** Bispecific T-Cell Engager; **CR:** Complete Response; **CrCl:** Creatinine Clearance; **CRS:** Cytokine Release Syndrome; **C:** Cycle; **CD:** Cluster of Differentiation; **D:** Day; **DLBCL:** Diffuse Large B Cell Lymphoma; **DLL3:** Delta-like ligand 3; **ES-SCLC:** Extensive Stage Small Cell Lung Cancer; **FFD:** First full dose; **FL:** Follicular Lymphoma; **G1:** Grade 1; **G2:** Grade 2; **G3:** Grade 3; **G4:** Grade 4; **G5:** Grade 5; **GGT** (gamma-glutamyl transferase), **GPRC5D:** G-protein-coupled receptor, class C, group 5, member D; **HLA:** Human Leukocyte Antigen; **ICANS:** Immune Effector Cell-Associated Neurotoxicity Syndrome; **IQR:** Interquartile Range; **IV:** Intravenous; **LBCL:** Large B-Cell Lymphoma; **MM:** Multiple Myeloma; **MRD:** Minimal Residual Disease; **N/A:** Not applicable; **NS:** Normal Saline; **PR:** Partial Response; **PTT:** Partial Thromboplastin Time; **R/R:** relapsed or refractory; **SC:** Subcutaneous; **SD:** Stable Disease; **VGPR:** Very Good Partial Response; **WBC:** White Blood Cell

TABLE 1: BTCEs IN LYMPHOMA (AS OF FEBRUARY 2026) *CONTINUED FROM PREVIOUS PAGE*

Drug	Mosunetuzumab-axgb (LUNSUMIO®, LUNSUMIO VELO™)[1–3]	Epcoritamab-bysp (EPKINLY®)[4,5]	Glofitamab-gxbm (COLUMVI™)[6,7]
Any Grade Adverse Events (with >25% Incidence)	Lymphopenia (84%–100%), hypophosphatemia (48%–78%), anemia (60%–68%), leukopenia (60%), neutropenia (50%–58%), thrombocytopenia (33%–46%), CRS (30%–44%), fatigue (39%–42%), hyperglycemia (42%), rash (35%–39%), increased AST (28%–39%), hypomagnesemia (25%–34%), hypokalemia (27%–33%), increased ALT (32%–34%), headache (17%–32%), pyrexia (11%–29%), hyperuricemia (22% to 28%), musculoskeletal pain (20%–28%)	Lymphopenia (87%–94%), anemia (59%–62%), hyponatremia (51%–56%), hypophosphatemia (LBCL: 56%), injection site reactions (FL: 58%; LBCL: 27%), leukopenia (53%–58%), neutropenia (50%–55%), CRS(49%–51%), thrombocytopenia (48%–49%), increased AST (44%–48%), increased ALT (45%–47%), serious infection (FL: 40%; LBCL: 15%), hypercreatininemia (FL: 36%; LBCL: 24%), fatigue (29%–37%), upper respiratory tract infection (FL: 29%; LBCL: <10%), skin rash (FL: 28%; LBCL: 15%), hypokalemia (FL: 20%; LBCL: 34%), increased ALP (FL: 29%), hyperbilirubinemia (FL: 28%), hypomagnesemia (FL: 20%; LBCL: 31%), musculoskeletal pain (28%), pyrexia (24%–26%), diarrhea (20%–26%)	Lymphopenia (90%), hypofibrinogenemia (84%), anemia (72%), CRS (70%), hypophosphatemia (69%), neutropenia (56%), thrombocytopenia (56%), hyponatremia (49%), hypocalcemia (48%), increased GGT (33%), hypokalemia (32%)
Grade 3 or > Adverse Events (with >25% Incidence)	Lymphopenia (22%–98%), hypophosphatemia (46%), hyperglycemia (42%), neutropenia (26%–40%)	Lymphopenia (77%–82%), neutropenia (14%–32%)	Lymphopenia (83%), hypophosphatemia (28%), neutropenia (26%)
REMS Program	No	No	No
Initial Approval	December 2022	May 2023 (LBCL), June 2024 (FL) Note: See Table 4 for information on epcoritamab in combination with lenalidomide and rituximab	June 2023
Pivotal Trial(s)	GO29781	EPCORE NHL-1	NP30179

ABBREVIATIONS: **ALL:** Acute Lymphoblastic Leukemia; **ALP:** alkaline phosphatase; **ALT:** Alanine Aminotransferase; **AST:** Aspartate Aminotransferase; **BCMA:** B-Cell Maturation Antigen; **BCP:** B-cell Precursor; **BTCE:** Bispecific T-Cell Engager; **CR:** Complete Response; **CrCl:** Creatinine Clearance; **CRS:** Cytokine Release Syndrome; **C:** Cycle; **CD:** Cluster of Differentiation; **D:** Day; **DLBCL:** Diffuse Large B Cell Lymphoma; **DLL3:** Delta-like ligand 3; **ES-SCLC:** Extensive Stage Small Cell Lung Cancer; **FFD:** First full dose; **FL:** Follicular Lymphoma; **G1:** Grade 1; **G2:** Grade 2; **G3:** Grade 3; **G4:** Grade 4; **G5:** Grade 5; **GGT** (gamma-glutamyl transferase), **GPRC5D:** G-protein-coupled receptor, class C, group 5, member D; **HLA:** Human Leukocyte Antigen; **ICANS:** Immune Effector Cell-Associated Neurotoxicity Syndrome; **IQR:** Interquartile Range; **IV:** Intravenous; **LBCL:** Large B-Cell Lymphoma; **MM:** Multiple Myeloma; **MRD:** Minimal Residual Disease; **N/A:** Not applicable; **NS:** Normal Saline; **PR:** Partial Response; **PTT:** Partial Thromboplastin Time; **R/R:** relapsed or refractory; **SC:** Subcutaneous; **SD:** Stable Disease; **VGPR:** Very Good Partial Response; **WBC:** White Blood Cell

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TABLE 2 (1 OF 2): BTCEs IN MULTIPLE MYELOMA (AS OF FEBRUARY 2026)

Drug	Teclistamab-cqyv (TECVAYLI®)[8, 9]				Talquetamab-tgvs (TALVEY®)[10, 11]			
Manufacturer	**Janssen Biotech, Inc.**				**Janssen Biotech, Inc.**			
Target	CD3xBCMA				CD3xGPRC5D			
Indication(s)	MM following 4 or more lines of therapy				MM following 4 or more lines of therapy			
Route of Administration	SC				SC			
Dosing Schedule	C1: Days 1, 4, 7 C2+: Weekly until progression For patients who have achieved and maintained a CR or better for >6 mo, consider biweekly dosing				Weekly Dosing C1: Days 1, 4, 7 C2+: Weekly until progression		Biweekly Dosing C1: Days 1, 4, 7, 10 C2+: Every 2 weeks until progression	
CRS Mitigation								
SUD Schedule	C1D1: 0.06 mg/kgC1D3: 0.3 mg/kg C1D5: 1.5 mg/kg (FFD)				Weekly Dosing C1D1: 0.01 mg/kg C1D4: 0.06 mg/kg C1D7: 0.4 mg/kg (FFD)		Biweekly Dosing C1D1: 0.01 mg/kg C1D4: 0.06 mg/kg C1D7: 0.4 mg/kg C1D10: 0.8 mg/kg (FFD)	
Premedications	(1) Acetaminophen 650–1,000 mg (or equivalent) for C1 (2) Diphenhydramine 50 mg (or equivalent) for C1 (3) Dexamethasone 16 mg for C1				(1) Acetaminophen 650–1,000 mg (or equivalent) for C1 (2) Diphenhydramine 50 mg (or equivalent) for C1 (3) Dexamethasone 16 mg (or equivalent) for C1			
Hospitalization	All SUDs and FFD: 48-h admission				All SUDs and FFD: 48-h admission			
CRS Incidence	G1	G2	G3	G4–5	G1	G2	G3	G4–5
	50%	21%	1%	0%	57%	17%	2%	0%
	Time course for CRS onset C1D1: 42% C1D3: 35% C1D5: 24% Subsequent doses: <3%		Median time to CRS onset All doses: 2 d (range: 1–6 d)		Time course for CRS onset Weekly Dosing C1D1: 29% C1D4: 44% C1D7: 30% Biweekly Dosing C1D7: 33% C1D10: 12%		Median time to CRS onset All doses: 27 h (range: 0.1–167 h)	
Median Duration of CRS	2 d (range: 1–9 d)				17 h (range: 1–622 h)			
ICANS Incidence	Any grade: 6%				Any grade: 9%			
Any Grade Adverse Events (with >25% Incidence)	Lymphopenia (92%), leukopenia (86%), neutropenia (84%), pyrexia (76%), CRS (72%), thrombocytopenia (71%), hypoalbuminemia (68%), anemia (67%), neurotoxicity (57%), musculoskeletal pain (44%), increased ALP (42%), hypophosphatemia (38%), increased GGT (37%), injection-site reaction (37%), hyponatremia (35%), increased AST (34%), fatigue (33%), hypocalcemia (31%), hypercreatininemia (30%), infection (30%), diarrhea (29%), increased ALT (28%), upper respiratory tract infection (26%), nausea (25%), headache (25%)				Lymphopenia (90%), pyrexia (83%), CRS (76%), leukopenia (73%), dysgeusia (49%–70%), anemia (67%), neutropenia (64%), weight loss (35%–62%), thrombocytopenia (62%), hypoalbuminemia (66%), neurotoxicity (55%), nail disorder (50%), increased ALP (49%), hypophosphatemia (44%), musculoskeletal pain (43%), skin disorder (41%), rash (38%), increased GGT (38%), fatigue (37%), xerostomia (34%), increased ALT (33%), increased AST (31%), hypokalemia (31%), hyponatremia (31%), xerosis (30%)			
Grade 3 or > Adverse Events (with >25% Incidence)	Neutropenia (64%), anemia (37%), lymphopenia (32%)				Lymphopenia (80%), leukopenia (35%), neutropenia (35%), anemia (30%)			
REMS Program	Yes				Yes			
Initial Approval	October 2022				August 2023			
Pivotal Trial(s)	MajesTEC-1				MonumenTAL-1			

ABBREVIATIONS: **ALL:** Acute Lymphoblastic Leukemia; **ALP:** alkaline phosphatase; **ALT:** Alanine Aminotransferase; **AST:** Aspartate Aminotransferase; **BCMA:** B-Cell Maturation Antigen; **BCP:** B-cell Precursor; **BTCE:** Bispecific T-Cell Engager; **CR:** Complete Response; **CrCl:** Creatinine Clearance; **CRS:** Cytokine Release Syndrome; **C:** Cycle; **CD:** Cluster of Differentiation; **D:** Day; **DLBCL:** Diffuse Large B Cell Lymphoma; **DLL3:** Delta-like ligand 3; **ES-SCLC:** Extensive Stage Small Cell Lung Cancer; **FFD:** First full dose; **FL:** Follicular Lymphoma; **G1:** Grade 1; **G2:** Grade 2; **G3:** Grade 3; **G4:** Grade 4; **G5:** Grade 5; **GGT** (gamma-glutamyl transferase), **GPRC5D:** G-protein-coupled receptor, class C, group 5, member D; **HLA:** Human Leukocyte Antigen; **ICANS:** Immune Effector Cell-Associated Neurotoxicity Syndrome; **IQR:** Interquartile Range; **IV:** Intravenous; **LBCL:** Large B-Cell Lymphoma; **MM:** Multiple Myeloma; **MRD:** Minimal Residual Disease; **N/A:** Not applicable; **NS:** Normal Saline; **PR:** Partial Response; **PTT:** Partial Thromboplastin Time; **R/R:** relapsed or refractory; **SC:** Subcutaneous; **SD:** Stable Disease; **VGPR:** Very Good Partial Response; **WBC:** White Blood Cell

TABLE 2 (2 OF 2): BTCEs IN MULTIPLE MYELOMA (AS OF FEBRUARY 2026)

Drug	Elranatamab-bcmm (ELREXFIO®)[12, 13]	Linvoseltamab-gcpt (LYNOZYFIC™)[14, 15]
Manufacturer	**Pfizer**	**Regeneron Pharmaceuticals, Inc.**
Target	CD3xBCMA	CD3xGPRC5D
Indication(s)	MM following 4 or more lines of therapy	MM following 4 or more lines of therapy
Route of Administration	SC	IV
Dosing Schedule	C1: Days 1, 4, 8 C2+: Weekly through Week 24 Weeks 25–48 (in patients achieving a PR or better at 24 weeks with response maintained for ≥2 months): Biweekly Week 49+ (for patients who have maintained the response following 24 weeks of treatment at the biweekly dosing schedule): Every 4 wk	C1: Days 1, 8, 15 C2+: Weekly through Week 13 Week 14+: Biweekly Week 24+ (for patients who have achieved and maintained VGPR or better at or after Week 24 and received at least 17 doses of 200 mg): Every 4 wk
CRS Mitigation		
SUD Schedule	C1D1: 12 mg C1D4: 32 mg C1D8: 76 mg (FFD)	C1D1: 5 mg C1D8: 25 mg C1D15: 200 mg (FFD)
Premedications	(1) Acetaminophen 650 mg (or equivalent) for C1 (2) Diphenhydramine 25 mg (or equivalent) for C1 (3) Dexamethasone 20 mg (or equivalent) for C1	1) Acetaminophen 650–1000 mg (or equivalent) for SUDs and first and second treatment doses (2) Diphenhydramine 25 mg (or equivalent) for SUDS and first and second treatment doses (3) Dexamethasone 40 mg (or equivalent) for SUDs and first treatment dose Once tolerated without CRS or infusion-related reactions, 10 mg dexamethasone (or equivalent) prior to the subsequent treatment dose
Hospitalization	C1D1: 48-h admission C1D4: 24-h admission	C1D1 and C1D8: 24-h admission
CRS Incidence	G1: 44%; G2: 14%; G3: 1%; G4–5: 0%	G1: 35%; G2: 10%; G3: 1%; G4–5: 0%
	Time course for CRS onset C1D1: 43% C1D4: 19% C1D8: 7% C2D1: 2%	Median time to CRS onset All doses: 2 d (range: 1–9 d)
	Time course for CRS onset C1D1: 38% C1D8: 17% C1D15: 10% C2D1: 4%	Median time for CRS onset All doses: 11 h (range: 1–184 h)
Median Duration of CRS	2 d (range: 1–19 d)	15 h (range: 1–76 h)
ICANS Incidence	Any grade: 3%	Any grade: 8%
Any Grade Adverse Events (with >25% Incidence)	Lymphopenia (91%), leukopenia (69%), anemia (68%), neutropenia (62%), thrombocytopenia (61%), neurotoxicity (59%), CRS (13%–58%), hypoalbuminemia (55%), fatigue (43%), severe infection (42%), increased AST (40%), hypercreatininemia (38%), injection-site reaction (37%), hypokalemia (36%), diarrhea (36%), increased ALT (36%), upper respiratory tract infection (36%), musculoskeletal pain (34%), increased ALP (34%), decreased CrCl (32%), pneumonia (25%–32%), decreased appetite (26%), skin rash (26%)	Lymphopenia (97%), anemia (72%), thrombocytopenia (64%), leukopenia (63%), neutropenia (62%), increased AST (61%), increased ALT (46%), hypophosphatemia(55%), neurotoxicity (54%), musculoskeletal pain (53%), hypercreatininemia (47%), CRS (46%), serious infection (42%), cough (39%), upper respiratory tract infection (35%), diarrhea (35%), fatigue (34%), pneumonia (28%)
Grade 3 or > Adverse Events (with >25% Incidence)	Lymphopenia (84%), neutropenia (51%), anemia (43%), leukopenia (40%), thrombocytopenia (32%)	Lymphopenia (92%), neutropenia (47%), anemia (42%), leukopenia (31%)
REMS Program	Yes	Yes
Initial Approval	August 2023	July 2025
Pivotal Trial(s)	MagnetisMM-3	LINKER-MM1

ABBREVIATIONS: **ALL:** Acute Lymphoblastic Leukemia; **ALP:** alkaline phosphatase; **ALT:** Alanine Aminotransferase; **AST:** Aspartate Aminotransferase; **BCMA:** B-Cell Maturation Antigen; **BCP:** B-cell Precursor; **BTCE:** Bispecific T-Cell Engager; **CR:** Complete Response; **CrCl:** Creatinine Clearance; **CRS:** Cytokine Release Syndrome; **C:** Cycle; **CD:** Cluster of Differentiation; **D:** Day; **DLBCL:** Diffuse Large B Cell Lymphoma; **DLL3:** Delta-like ligand 3; **ES-SCLC:** Extensive Stage Small Cell Lung Cancer; **FFD:** First full dose; **FL:** Follicular Lymphoma; **G1:** Grade 1; **G2:** Grade 2; **G3:** Grade 3; **G4:** Grade 4; **G5:** Grade 5; **GGT** (gamma-glutamyl transferase), **GPRC5D:** G-protein-coupled receptor, class C, group 5, member D; **HLA:** Human Leukocyte Antigen; **ICANS:** Immune Effector Cell-Associated Neurotoxicity Syndrome; **IQR:** Interquartile Range; **IV:** Intravenous; **LBCL:** Large B-Cell Lymphoma; **MM:** Multiple Myeloma; **MRD:** Minimal Residual Disease; **N/A:** Not applicable; **NS:** Normal Saline; **PR:** Partial Response; **PTT:** Partial Thromboplastin Time; **R/R:** relapsed or refractory; **SC:** Subcutaneous; **SD:** Stable Disease; **VGPR:** Very Good Partial Response; **WBC:** White Blood Cell

TABLE 3: BTCEs IN OTHER INDICATIONS (AS OF FEBRUARY 2026)

Drug	Blinatumomab (BLINCYTO®)[16–19]	Tebentafusp-tebn (KIMMTRAK®)[20,21]	Tarlatamab-dlle (IMDELLTRA ®)[22–24]
Manufacturer	Amgen, Inc.	Immunocore Commercial LLC	Amgen, Inc.
Target	CD3xCD19	CD3xgp100peptide-HLA	CD3xDLL3
Indication(s)	(1) MRD+ BCP-ALL (2) R/R BCP-ALL (3) BCP-ALL in the consolidation phase	HLA-A*02:01-positive unresectable or metastatic uveal melanoma	ES-SCLC following progression on platinum-based chemotherapy
Route of Administration	IV	IV	IV
Dosing Schedule	MRD+ BCP-ALL and BCP-ALL in consolidation phase Induction Cycle 1: Days 1–28 then 14 d off Consolidation Cycles 2–4: Days 1–28 then 14 d off R/R BCP-ALL Induction C1 and C2: Days 1–28 then 14 days off Consolidation C3–5: Days 1–28 then 14 days off Continued Therapy C6–9: Days 1–28 then 56 days off	Once weekly until progression	C1: Days 1, 8 ,15 C2+: Days 1 and 15; every 28 d until progression
CRS Mitigation			
SUD Schedule	R/R BCP-ALL, Induction Cycle 1: Days 1–7: 9 mcg/d Days 8–28: 28 mcg/d Note: See PI for dosing for patients under 45 kg	D1: 20 mcg D8: 30 mcg D15: 68 mcg (FFD)	C1D1: 1 mg C1D8: 10 mg (FFD) C1D15: 10 mg
Premedications	MRD+ BCP-ALL and BCP-ALL in consolidation phase Corticosteroid: Prednisone 100 mg (or equivalent) D1 in each cycle For adults with R/R BCP-ALL Corticosteroid: Dexamethasone 20 mg D1 in each cycle, prior to a step-up dose, and when restarting an infusion after interruption of ≥4 h	None	(1) Dexamethasone 8 mg (or equivalent) on C1D1 and C1D8 (2) 1L NS IV over 4–5 h immediately after infusion completion on C1D1, C1C8, and C1D15
Hospitalization	MRD+ BCP-ALL and BCP-ALL in consolidation phase: C1 (3 d) and C2 (2 d) R/R BCP-ALL: C1 (9 d), C2 (2 d)	D1, D8, and D15: 16 h monitoring Monitoring should be done in an appropriate healthcare setting	C1D1, C1D8: 22–24 h monitoring C1D15: 6–8 h monitoring Subsequent infusions: 2 h monitoring Monitoring should be done in an appropriate healthcare setting
CRS Incidence	MRD+ BCP-ALL (any grade): 15% R/R BCP-ALL (any grade): 7% BCP-ALL in consolidation phase (any grade): 16%	G1: 12%; G2: 76%; G3: 1%; G4-5: 0%	G1: 34%; G2: 19%; G3: 1%; G4: 0.5%; G5: 0%
	Time course for CRS onset: Not reported Median time to CRS onset: All doses: 2 d	Time course for CRS onset Day 1: 85% Day 8: 75% Day 15: 60% Day 22: 30% Day 29: 10% Median time to CRS onset: All doses: Within the day of the infusion	Time course for CRS onset C1D1: 39% C1D8: 28% C1D15: 6% C1D1: 2% Median time to CRS onset: All doses: 14 h (range: 1–268 h)
Median Duration of CRS	5 d	2 d	4 d (IQR 2–6 d)
ICANS Incidence	Any grade: 8%	N/A	G1: 5%; G2–4: 4%; G5: 0%

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ABBREVIATIONS: **ALL:** Acute Lymphoblastic Leukemia; **ALP:** alkaline phosphatase; **ALT:** Alanine Aminotransferase; **AST:** Aspartate Aminotransferase; **BCMA:** B-Cell Maturation Antigen; **BCP:** B-cell Precursor; **BTCE:** Bispecific T-Cell Engager; **CR:** Complete Response; **CrCl:** Creatinine Clearance; **CRS:** Cytokine Release Syndrome; **C:** Cycle; **CD:** Cluster of Differentiation; **D:** Day; **DLBCL:** Diffuse Large B Cell Lymphoma; **DLL3:** Delta-like ligand 3; **ES-SCLC:** Extensive Stage Small Cell Lung Cancer; **FFD:** First full dose; **FL:** Follicular Lymphoma; **G1:** Grade 1; **G2:** Grade 2; **G3:** Grade 3; **G4:** Grade 4; **G5:** Grade 5; **GGT** (gamma-glutamyl transferase), **GPRC5D:** G-protein-coupled receptor, class C, group 5, member D; **HLA:** Human Leukocyte Antigen; **ICANS:** Immune Effector Cell-Associated Neurotoxicity Syndrome; **IQR:** Interquartile Range; **IV:** Intravenous; **LBCL:** Large B-Cell Lymphoma; **MM:** Multiple Myeloma; **MRD:** Minimal Residual Disease; **N/A:** Not applicable; **NS:** Normal Saline; **PR:** Partial Response; **PTT:** Partial Thromboplastin Time; **R/R:** relapsed or refractory; **SC:** Subcutaneous; **SD:** Stable Disease; **VGPR:** Very Good Partial Response; **WBC:** White Blood Cell

TABLE 3: BTCEs IN OTHER INDICATIONS (AS OF FEBRUARY 2026) *CONTINUED FROM PREVIOUS PAGE*

Drug	Blinatumomab (BLINCYTO®)[16–19]	Tebentafusp-tebn (KIMMTRAK®)[20, 21]	Tarlatamab-dlle (IMDELLTRA®)[22–24]
Any Grade Adverse Events (with >25% Incidence)	Pyrexia (55%–91%), lymphocytopenia (80%), infusion-related reactions (30%–77%), headache (23%–39%), neurotoxicity (65%), infections (28%–39%), tremor (31%), neutropenia (15%–31%), anemia (infants, children, adolescents: 41%; adults: 24%–25%), chills (28%), thrombocytopenia (infants, children, adolescents: 34%; adults: 10%–21%), hypertension (infants, children, adolescents: 26%; adults: 8%)	Lymphocytopenia (91%), CRS (89%), hypercreatininemia (87%), skin rash (83%), pyrexia (76%), pruritus (69%), hyperglycemia (66%), increased ALT (≤65%), increased AST (≤65%), fatigue (64%), anemia (51%), hypophosphatemia (51%), chills (48%), hypoalbuminemia (47%), hypocalcemia (45%), abdominal pain (45%), edema (45%), nausea (49%), hypotension (39%), hyperlipasemia (37%), hypomagnesemia (34%), increased ALP (34%), antibody development (29%–33%), headache (31%), xeroderma (31%), vomiting (30%), hyponatremia (30%), hyperkalemia (29%), hypopigmentation (28%), skin edema (27%), hyperbilirubinemia (27%), diarrhea (25%), erythema of skin (24%–25%)	Lymphocytopenia (65%–84%), neurotoxicity (≤65%), hyponatremia (57%–68%), CRS (55%–56%), anemia (51%–58%), fatigue (39%–51%), leukopenia (44%–50%), hypokalemia (41%–50%), increased AST (40%–44%), increased ALT (32%–42%), infection (43%), pyrexia (29%–36%), decreased appetite (34%–37%), dysgeusia (28%–36%), thrombocytopenia (25%–33%), hypomagnesemia (21–33%), musculoskeletal pain (27%–30%), constipation (30%), hypercreatininemia (23%–29%), hypernatremia (26%–35%), prolonged PTT (26%), nausea (22%–25%)
Grade 3 or > Adverse Events (with >25% Incidence)	Lymphocytopenia (80%), neutropenia (15% to 28%)	Lymphocytopenia (56%)	Lymphocytopenia (27%–57%)
REMS Program	No	No	No
Initial Approval	December 2014	January 2022	May 2024
Pivotal Trial(s)	BLAST, TOWER, ECOG-ACRIN E1910	IMCgp100-202	DeLLphi-301, DeLLphi-304

ABBREVIATIONS: ALL: Acute Lymphoblastic Leukemia; **ALP:** alkaline phosphatase; **ALT:** Alanine Aminotransferase; **AST:** Aspartate Aminotransferase; **BCMA:** B-Cell Maturation Antigen; **BCP:** B-cell Precursor; **BTCE:** Bispecific T-Cell Engager; **CR:** Complete Response; **CrCl:** Creatinine Clearance; **CRS:** Cytokine Release Syndrome; **C:** Cycle; **CD:** Cluster of Differentiation; **D:** Day; **DLBCL:** Diffuse Large B Cell Lymphoma; **DLL3:** Delta-like ligand 3; **ES-SCLC:** Extensive Stage Small Cell Lung Cancer; **FFD:** First full dose; **FL:** Follicular Lymphoma; **G1:** Grade 1; **G2:** Grade 2; **G3:** Grade 3; **G4:** Grade 4; **G5:** Grade 5; **GGT** (gamma-glutamyl transferase), **GPRC5D:** G-protein-coupled receptor, class C, group 5, member D; **HLA:** Human Leukocyte Antigen; **ICANS:** Immune Effector Cell-Associated Neurotoxicity Syndrome; **IQR:** Interquartile Range; **IV:** Intravenous; **LBCL:** Large B-Cell Lymphoma; **MM:** Multiple Myeloma; **MRD:** Minimal Residual Disease; **N/A:** Not applicable; **NS:** Normal Saline; **PR:** Partial Response; **PTT:** Partial Thromboplastin Time; **R/R:** relapsed or refractory; **SC:** Subcutaneous; **SD:** Stable Disease; **VGPR:** Very Good Partial Response; **WBC:** White Blood Cell

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Kelly Brunk

Madelyn Floysand

Chart updated by **Kelly Brunk**, PharmD, MBA, BCOP, Senior Manager of Clinical Excellence at NCODA, Yorkville, Illinois, and **Madelyn Floysand,** PharmD, Oncology, Advocacy, Health Policy & Equity Fellow at NCODA, Denver.

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TABLE 4 (1 OF 2): BTCEs IN COMBINATION REGIMENS (AS OF FEBRUARY 2026)

<table>
<tr><th>Combination</th><th>Epcoritamab-bysp (EPKINLY®) and R² (Lenalidomide and Rituximab)[25]</th><th>Teclistamab-cqyv (TECVAYLI®) and Talquetamab-tgvs (TALVEY®)[26,27]</th></tr>
<tr><td>Indication</td><td>FL following 1 or more lines of therapy</td><td>MM following 4 or more lines of therapy</td></tr>
<tr><td>Dosing Schedule</td><td>Cycle length: 28 d
<table><tr><th>Epcoritamab</th><th>Lenalidomide</th><th>Rituximab</th></tr><tr><td>C1-3: Day 1, 8 ,15, and 22
C4-12: Day 1</td><td>C1-12: QD, Days 1-21</td><td>C1: Day 1, 8, 15, 22
C2-5: Day 1</td></tr></table></td><td>Cycle length: 28 d
C1: 3 SUDs administered 2–4 days apart and prior to FFD
C2: Teclistamab and talquetamab biweekly
C4+ (if PR or better is achieved): Teclistamab and talquetamab monthly until progression</td></tr>
<tr><td>CRS Mitigation</td><td></td><td></td></tr>
<tr><td>SUD Schedule</td><td>C1D1: 0.16 mg
C1D8: 0.8 mg
C1D15: 3 mg
C1D22: 48 mg (FFD)</td><td><table><tr><th>SUD</th><th>Talquetamab</th><th>Teclistamab</th></tr><tr><td>SUD 1</td><td>0.01 mg/kg</td><td>0.06 mg/kg</td></tr><tr><td>SUD 2</td><td>0.06 mg/kg</td><td>0.3 mg/kg</td></tr><tr><td>SUD 3</td><td>0.4 mg/kg</td><td>1.5 mg/kg</td></tr><tr><td>FFD</td><td>0.8 mg/kg</td><td>3 mg/kg</td></tr></table>Teclistamab is administered before talquetamab.</td></tr>
<tr><td>Premedications</td><td>(1) Acetaminophen 650–1,000 mg
(2) Diphenhydramine 50 mg (or equivalent)
(3) Dexamethasone 15 mg or prednisolone 100 mg (or equivalent), before C1 treatments and for 3 consecutive days after

Continue dexamethasone thereafter if G2 or G3 CRS with prior dose</td><td>(1) Acetaminophen 650–1,000 mg (or equivalent) for C1
(2) Diphenhydramine 50 mg (or equivalent) for C1
(3) Dexamethasone 16 mg for C1</td></tr>
<tr><td>Hospitalization</td><td>Consider</td><td>For 48 h after administration of all SUDs and FFD</td></tr>
<tr><td>CRS Incidence</td><td><table><tr><td>G1</td><td>G2</td><td>G3–4</td><td>G5</td></tr><tr><td>19%</td><td>5%</td><td>12%</td><td>0%</td></tr></table>Time course for CRS onset
C1D1: 5%
C1D8: 4%
C1D15: 2%
C1D22: 18%

Median time to onset of CRS
From the most recent dose: 78 h (range: 0.2–12 d)

After the FFD: 41 h (range: 0.3–12 d)</td><td><table><tr><td>G1–2</td><td>G3</td><td>G4–5</td></tr><tr><td>77%</td><td>2%</td><td>0%</td></tr></table>Median time to onset and duration of CRS
were 2 days each.</td></tr>
<tr><td>ICANS Incidence</td><td>Any grade: 1%</td><td>Any grade: 3% (G3: 1%)</td></tr>
<tr><td>What is Different Between the Single Agent(s) and Combination Therapy?</td><td>• When epcoritamab is used as a single agent for FL, it is continued until disease progression or unacceptable toxicity. When used with R², treatment is continued for a total of 12 cycles or until disease progression or unacceptable toxicity, whichever occurs first.
• CRS occurred in fewer patients when used in combination with R² (26%) versus monotherapy (49%).
• When epcoritamab is used in combination with R², dosing shifts to once per cycle beginning in Cycle 4, with administration only on Day 1 for Cycles 4 and beyond.</td><td>• Step up dosing is different.
• In combination, talquetamab is administered every 2 weeks, while teclistamab is given at a higher dose and less frequent interval (3 mg/kg every 2 weeks) compared with weekly dosing when used as monotherapy (1.5 mg/kg every week).</td></tr>
<tr><td>Additional Considerations</td><td>• REMS program with lenalidomide</td><td>• Both agents require unique REMS Dispense Authorizations (RDAs).</td></tr>
<tr><td>Any Grade Adverse Events (with >25% Incidence)</td><td>Rash (46%), upper respiratory tract infections (33%), fatigue (31%), injection-site reactions (27%), constipation (26%)</td><td>CRS (79%), neutropenia (73%), taste changes (65%), nonrash skin adverse event (61%), anemia (56%), nail-related adverse event (52%), pyrexia (51%), diarrhea (48%), cough (45%), dry mouth (43%), thrombocytopenia (43%), COVID-19 (40%), rash adverse event (39%), pneumonia (36%), weight decrease (34%), fatigue (28%)</td></tr>
<tr><td>Grade 3 or > Adverse Events (with >25% Incidence)</td><td>None</td><td>Neutropenia (68%), anemia (38%), thrombocytopenia (30%)</td></tr>
<tr><td>Initial Approval</td><td>November 18, 2025</td><td>Not FDA-approved as of February 2, 2026</td></tr>
<tr><td>Pivotal Trial</td><td>EPCORE FL-1</td><td>RedirecTT-1</td></tr>
</table>

TABLE 4 (2 OF 2): BTCEs IN COMBINATION REGIMENS (AS OF FEBRUARY 2026)

Combination	Epcoritamab-bysp (EPKINLY®) and GEMOX (Gemcitabine and Oxaliplatin)[28]	Glofitamab-gxbm (COLUMVI™) and GEMOX (Gemcitabine and Oxaliplatin)[29]
Indication	DLBCL following 1 or more lines of therapy	DLBCL following 1 or more lines of therapy
Dosing Schedule	Cycle length: 28 d **Epcoritamab**: C1-3: Day 1, 8 ,15, and 22; C4-12: Day 1 **GEMOX**: C1-4: Gemcitabine: Day 1 and 15; Oxaliplatin: Day 1 and 15	Cycle length: 21 d **Obinutuzumab**: C1D1 only **Glofitamab**: C1: Day 8 and Day 15; C2-12: Day 1 **GEMOX**: C1-8: Gemcitabine: Day 1; Oxaliplatin: Day 1
CRS Mitigation		
SUD Schedule	C1D1: 0.16 mg C1D8: 0.8 mg C1D15: 48 mg (FFD) C1D22: 48 mg	C1D1: Obinutuzumab C1D8: 2.5 mg (first dose of glofitamab) C1D15: 10 mg C2D1: 30 mg (FFD)
Premedications	(1) Acetaminophen 650–1,000 mg (2) Diphenhydramine 50 mg (or equivalent) (3) Dexamethasone 15 mg or prednisolone 100 mg (or equivalent), before C1 treatments and for 3 consecutive days after Continue dexamethasone thereafter if G2 or G3 CRS with prior dose.	(1) Acetaminophen 500–1,000 mg (2) Diphenhydramine 50 mg (or equivalent) (3) Dexamethasone 20 mg (or equivalent) on C1D8, C1D15, C2D1, and C3D1. Continue if CRS occurs with prior dose.
Hospitalization	C1D15 (FFD): 24-h admission	C1D8 (first glofitamab dose): 24-h admission
CRS Incidence	G1: 28%; G2: 23%; G3: 1%; G4–5: 0% Time course for CRS onset: C1: 84%; C1D15 (FFD): 63% Median time to onset of CRS: Most events occurred in C1 following FFD.	G1: 31%; G2: 11%; G3: 2%; G4–5: 0% Time course for CRS onset: C1D8: 35%; C1D15: 13%; C2D1: 11%; C3D1: 7%; C4+: 11% Median time to onset of CRS: C1D8: 14 h; C1D15: 32 h; C2D1: 38 h; C3+: 37 h
ICANS Incidence	Any grade: 3% (G3: 1%)	Any grade: 2% (G3: 1%)
Difference Between Single Agent(s) and Combination Therapy?	• Combination allows dose-dense GemOx without new safety signals.	• Glofitamab combination therapy retains the same obinutuzumab lead-in and step-up dosing strategy as monotherapy; differences are primarily related to the addition of fixed-duration chemotherapy rather than changes to glofitamab administration.
Additional Considerations	• Fixed duration GemOx	• Fixed duration GemOx • A single dose of obinutuzumab is administered on C1D1, 7 days prior to the first glofitamab dose, for CRS mitigation.
Any Grade Adverse Events (with >25% Incidence)	Thrombocytopenia (73%), infections (72%), neutropenia (65%), anemia (59%), CRS (52%), diarrhea (47%), nausea (40%), fatigue (35%), hypokalemia (31%), pyrexia (29%), COVID-19 (29%), increased ALT (28%), increased AST (25%), peripheral neuropathy (25%)	Thrombocytopenia (48%), CRS (44%), neutropenia (42%), anemia (41%), nausea (39%), peripheral neuropathy (36%), diarrhea (34%), increased AST (33%), increased ALT (32%)
Grade 3 or > Adverse Events (with >25% Incidence)	Thrombocytopenia (59%), neutropenia (57%), anemia (43%), infections (29%)	Not reported.
Initial Approval	Not FDA-approved as of February 2, 2026	Not FDA-approved as of February 2, 2026
Pivotal Trial	EPCORE NHL-2	STARGLO

ABBREVIATIONS: **ALL:** Acute Lymphoblastic Leukemia; **ALP:** alkaline phosphatase; **ALT:** Alanine Aminotransferase; **AST:** Aspartate Aminotransferase; **BCMA:** B-Cell Maturation Antigen; **BCP:** B-cell Precursor; **BTCE:** Bispecific T-Cell Engager; **CR:** Complete Response; **CrCl:** Creatinine Clearance; **CRS:** Cytokine Release Syndrome; **C:** Cycle; **CD:** Cluster of Differentiation; **D:** Day; **DLBCL:** Diffuse Large B Cell Lymphoma; **DLL3:** Delta-like ligand 3; **ES-SCLC:** Extensive Stage Small Cell Lung Cancer; **FFD:** First full dose; **FL:** Follicular Lymphoma; **G1:** Grade 1; **G2:** Grade 2; **G3:** Grade 3; **G4:** Grade 4; **G5:** Grade 5; **GGT** (gamma-glutamyl transferase), **GPRC5D:** G-protein-coupled receptor, class C, group 5, member D; **HLA:** Human Leukocyte Antigen; **ICANS:** Immune Effector Cell-Associated Neurotoxicity Syndrome; **IQR:** Interquartile Range; **IV:** Intravenous; **LBCL:** Large B-Cell Lymphoma; **MM:** Multiple Myeloma; **MRD:** Minimal Residual Disease; **N/A:** Not applicable; **NS:** Normal Saline; **PR:** Partial Response; **PTT:** Partial Thromboplastin Time; **R/R:** relapsed or refractory; **SC:** Subcutaneous; **SD:** Stable Disease; **VGPR:** Very Good Partial Response; **WBC:** White Blood Cell

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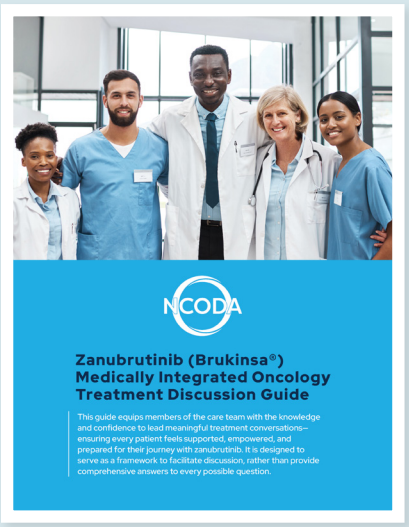
Effective patient education requires personalized, role-specific guidance to ensure patients fully understand their therapy, treatment goals, and potential challenges. The **NCODA Medically Integrated Oncology Treatment Discussion Guide** provides tailored educational pearls for each member of the medically integrated care team, highlighting their unique contributions to the patient experience.

Our first Treatment Discussion Guide, focused on **zanubrutinib**. We are proud to expand the series with a second guide featuring **nirogacestat.** Together, these resources mark the beginning of a growing library designed to support additional therapies and empower care teams in every aspect of patient-centered oncology.



NCODA's Treatment Discussion Guides are made possible through the strength of our partnerships. By working together, we can continue to create meaningful resources that elevate the role of the medically integrated oncology care team and improve patient outcomes.

Partners interested in learning more about how to support or get involved with this initiative are encouraged to connect with the NCODA Partner Development team at **partnership@ncoda.org** for details.

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NCODA's Clinical White Papers are evidence-informed resources developed by expert oncology professionals to support high-quality, patient-centered care across a wide range of clinical and operational challenges.

Designed for multidisciplinary oncology teams, these papers translate real-world experience and emerging evidence into actionable strategies that enhance outcomes, refine workflows and support best practices in everyday clinical settings.

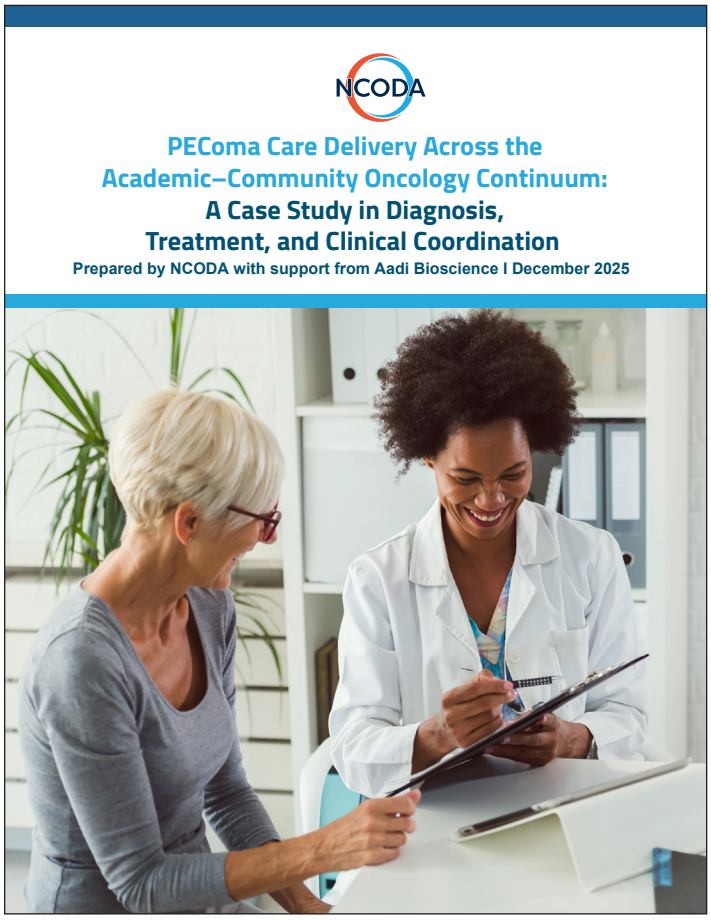
White papers differ from traditional research articles in that they blend clinical insight with practical application. Each paper addresses a specific issue — from rare disease care delivery to treatment decision frameworks and cost-effective strategies — offering both background evidence and practice recommendations.

They help physicians, pharmacists, nurses and administrators bridge the gap between academic advances and clinical implementation, supporting care teams in delivering consistent, informed care.

NCODA curates its white papers to reflect evolving standards of care, emerging treatment paradigms and operational challenges faced by oncology professionals.

Topics may include precision dosing strategies, imaging and therapy innovations, therapy sequencing, or safety testing and implementation considerations.

Authors typically include clinicians and academicians with deep expertise in the subject matter, providing readers with robust, practical content that can be applied in community and academic practice environments.



One of NCODA's latest Clinical White Papers focuses on PEComa Care delivery across the academic community oncology continuum. More pages from the paper can be found on the next page.

RECENT NCODA CLINICAL WHITE PAPERS

Below are recent white papers available from NCODA's resource library:

▲ **PEComa Care Delivery Across the Academic–Community Oncology Continuum:** This white paper examines the unique diagnostic and treatment challenges presented by perivascular epithelioid cell tumors (PEComas), using perspectives from both academic and community settings to illustrate how care is optimized across diverse practice environments.

▲ **Provider Perspectives on Clinical and Nonclinical Considerations in BTKi Selection:** Bruton tyrosine kinase inhibitors (BTKis) have reshaped B-cell malignancy management. This paper synthesizes a national provider survey to explore how clinical and nonclinical factors influence BTKi selection, highlighting operational realities and decision-making complexities.

▲ **Prostate Cancer: Imaging and Therapy Options from an Oncology Perspective:** Outlining advances in prostate cancer imaging and radiopharmaceutical therapy, this paper highlights practical adoption strategies for PSMA-targeted diagnostics

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CLINICAL WHITE PAPERS

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and therapies like Pluvicto® and Xofigo®, helping practices integrate these innovations into routine care.

▲ **Low-Dose Abiraterone with a Low-Fat Diet in Metastatic Prostate Cancer:** A case series from the Fred Hutchinson Cancer Center explores using low-dose abiraterone taken with a low-fat meal as a cost-effective approach with comparable efficacy and manageable safety, underscoring the potential for diet-adjusted therapy protocols in practice.

▲ **Universal DPYD Testing Prior to 5-FU and Capecitabine Therapy:** This paper outlines the clinical, economic and policy rationale for routine DPYD testing prior to administering Fluorouracil (5-FU) and capecitabine. Evidence shows genotype-guided dosing can prevent severe toxicities and align U.S. practice with international safety standards.

▲ **Redefining Oncology Distribution:** This paper examines the evolving landscape of oncology medication distribution, particularly the role of medically integrated dispensing pharmacies in improving coordinated care, therapy access and operational alignment with clinical decision-making.

For more information about **NCODA Clinical White Papers**, scan the QR code above.

APPLYING WHITE PAPERS IN PRACTICE

Clinical white papers are more than academic summaries — they are tools practices can use to inform guideline development, shape internal protocols, support education and training, and guide multidisciplinary discussion. They also provide valuable context when evaluating new therapies, refining symptom management approaches or advocating for practice-level changes.

Oncology teams can incorporate insights from these papers into quality improvement initiatives, staff education and patient communication strategies.

For example, a white paper highlighting the importance of genotype-guided dosing may prompt a clinic to adopt DPYD-testing workflows, while imaging and therapy reviews can inform local protocols for integrating new diagnostic technologies.

NCODA's commitment to producing clinically relevant white papers underscores its broader mission to support oncology professionals with resources that are both evidence-based and deeply practical.

Whether your practice is evaluating emerging therapies, optimizing care pathways or addressing rare malignancies, these papers offer timely insight rooted in real-world oncology practice.

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Introduction

Perivascular epithelioid cell tumors (PEComas) are a rare and heterogeneous group of mesenchymal neoplasms characterized by the co-expression of melanocytic and smooth muscle markers. These tumors may arise in various anatomic locations including the uterus, retroperitoneum, lung, and gastrointestinal tract. PEComas may present with nonspecific symptoms such as abdominal pain, bleeding, or incidental mass findings.[1,2] PEComas are frequently misdiagnosed or detected late in the disease course due to their rarity and clinical overlap with other soft tissue malignancies like leiomyosarcoma, gastrointestinal stromal tumor (GIST), or renal cell carcinoma.[2]

Historically, treatment options for unresectable or metastatic PEComa were limited to off-label use of oral mTOR inhibitors, which often resulted in variable efficacy and inconsistent tolerability.[2] However, the FDA approval of *nab*-sirolimus (Fyarro®), the first and only approved therapy for malignant PEComa, has reshaped the treatment paradigm.[3] *Nab*-sirolimus offers a targeted approach that improves tumor control and progression-free survival while providing a manageable safety profile.[4]

Because of its rarity, optimal PEComa care requires collaboration across healthcare settings. Academic medical centers play a critical role in establishing the diagnosis through expert pathology and molecular diagnostics, initiating evidence-based therapy, and offering access to clinical trials. Yet, the majority of ongoing cancer care in the U.S. takes place in community settings, where patients receive most of their treatment and follow-up.[5,6] As a result, a shared care model, anchored in communication, continuity, and aligned protocols is essential to ensure that patients with PEComa benefit from cutting-edge science without losing access to local support.

This case study explores the real-world experiences of both an academic sarcoma center and a high-volume community oncology network. It highlights the institutional pathways, treatment decision-making, and coordination mechanisms that have been implemented to optimize PEComa diagnosis, treatment with *nab*-sirolimus, patient support, and long-term outcomes. By examining care delivery from both ends of the referral spectrum, this report provides a comprehensive model for how to operationalize rare tumor care through collaboration, education, and clinical leadership.

Challenges in Diagnosing PEComa Across Sites of Care

Diagnosing PEComa is inherently complex due to its rarity, histologic variability, and overlapping clinical features with other more common tumors.[2] These challenges manifest differently in academic and community oncology settings, though both environments face critical diagnostic inflection points that influence patient outcomes.

1. Diagnostic Complexity at Academic Medical Centers

At academic institutions, providers are more likely to encounter referrals for second opinions on difficult-to-classify soft tissue tumors. Despite this, PEComa can still elude immediate recognition, particularly in its uterine or retroperitoneal forms, where symptoms are often vague or mimic other gynecologic or abdominal conditions.[7] Patients may present with abnormal bleeding, nonspecific pelvic pain, or incidental mass findings during unrelated imaging studies.

Even in highly specialized settings, diagnosis hinges on expert pathology review. Immunohistochemistry for melanocytic markers (HMB-45, Melan-A) and muscle markers (SMA, desmin) are essential for accurate identification.[1] The academic site highlighted in this case study noted that most of their PEComa cases were originally misdiagnosed as leiomyosarcoma, GIST, or renal cell carcinoma. Only through multidisciplinary tumor board review and high-level pathology collaboration was the correct diagnosis made.

The academic team emphasized the importance of internal communication between departments, particularly gynecologic oncology and sarcoma services, to ensure uterine PEComa cases are appropriately classified and co-managed. Furthermore, they often serve as the "diagnostic endpoint" for patients who had previously seen multiple providers without definitive answers.

> ***"We frequently see second opinions initiated by referring providers, often after pathology was inconclusive or misclassified. Pathology is central to the diagnostic process in PEComa."***
>
> – Academic Medical Center Provider

2. Diagnostic Gaps in the Community Setting

In the community oncology environment, providers face the additional challenge of identifying PEComa among a broad and diverse case mix. While large practices may see thousands of cancer cases annually, the appearance of a PEComa diagnosis is rare and often unexpected. As such, it is common for patients to first be treated under the assumption of a more typical soft tissue malignancy.

PEComa Care Delivery Across the Academic–Community Oncology Continuum

Community oncologists typically rely on external referrals from academic centers for the diagnosis of PEComa. These patients arrive with diagnostic workups and treatment plans already in place. However, when the diagnosis originates locally, delays may occur due to limited access to comprehensive molecular testing or a lack of familiarity with the disease.

Community practices may also face practical constraints when pursuing confirmatory diagnostics, such as limited in-house pathology resources or delays in outsourcing biopsies for advanced staining or NGS. These barriers can lead to reliance on empirical treatment approaches that are not tailored to PEComa biology, further underscoring the value of collaboration with academic sarcoma programs.

> ***"We most often see patients with PEComa after they've been diagnosed at a tertiary center. In some cases, we've treated them based on a preliminary diagnosis that later changed after academic pathology review."***
>
> – Community Oncology Provider

3. Shared Challenges and Points of Convergence

Both academic and community sites encounter overlapping diagnostic challenges, particularly around:

- Limited clinical suspicion for PEComa due to its rarity
- Overlap in presentation with more common malignancies
- Lack of standardized diagnostic algorithms or screening criteria
- Difficulty in accessing timely and definitive molecular results

As a result, establishing the correct diagnosis of PEComa remains a pivotal moment in the patient journey as it determines treatment eligibility, prognosis, and long-term care strategy. The data gathered from both sites reinforce the critical role of pathology, the value of multidisciplinary review, and the necessity of maintaining strong academic-community referral pathways to expedite diagnosis and avoid inappropriate treatment.

Treatment Decision-Making and Adoption of *Nab*-sirolimus: Divergent Paths, Aligned Purpose

Once PEComa is accurately diagnosed, treatment decisions must be made rapidly and thoughtfully, balancing disease aggressiveness with therapeutic efficacy, toxicity profiles, and patient preferences. The approval of *nab*-sirolimus in 2021 marked a significant milestone in PEComa care, offering the first FDA-approved therapy specifically indicated for this rare malignancy.[3] Both academic and community sites now use *nab*-sirolimus, but their paths to adoption and the decision-making frameworks differ in meaningful ways.

1. Academic Centers: Data-Driven Adoption

Academic institutions, often at the forefront of clinical trial participation and guideline development, were among the first to adopt *nab*-sirolimus into routine practice. In the highlighted academic sarcoma center, the medical team had been closely following the AMPECT trial results and was prepared to integrate *nab*-sirolimus into clinical pathways as soon as it received FDA approval.

Adoption was facilitated by multidisciplinary tumor boards, institutional protocols, and a culture of rapid knowledge translation. For unresectable or metastatic PEComa, *nab*-sirolimus quickly replaced off-label mTOR inhibitors like sirolimus and everolimus, which had shown inconsistent efficacy and higher toxicity in the real-world setting.[2]

> ***"We transitioned to Fyarro based on both trial data and our early patient experiences. It's more effective, better tolerated, and easier to manage than the oral agents we previously used."***
>
> – Academic Medical Center Provider

Academic teams emphasized the value of *nab*-sirolimus' albumin-bound formulation, which enhances drug delivery and reduces systemic side effects. Side effect profiles are closely tracked using standardized grading systems, and internal supportive care protocols (including dexamethasone mouthwash and proactive fatigue management) were rapidly implemented across departments.

2. Community Practices: Guided by Expertise, Grounded in Access

In the community setting, *nab*-sirolimus adoption has been equally important but followed a more consultative path. Community oncologists often initiate treatment based on detailed recommendations from academic partners who made the initial diagnosis. These handoffs include dosing guidelines, toxicity monitoring parameters, and clear escalation pathways should complications arise.

HONORING VETERANS WITH COMPASSIONATE, COORDINATED CANCER CARE

Veterans face unique challenges when it comes to cancer treatment, from higher rates of exposure-related cancers to complex health histories and barriers to accessing timely care. NCODA is dedicated to supporting our veterans by equipping oncology professionals with the tools, education, and resources needed to deliver patient-centered, high-quality cancer care.

Through NCODA's new Veterans Care web page, you can access a wide variety of resources and pathways to Veteran foundations and government support information.

Join us in advancing care for Veterans.
Learn more and get involved at **ncoda.org/veterans**

Featured Editorial

PATIENT MANAGEMENT IN VETERAN HEALTH

Featured Editorial

SERVING THOSE WHO SERVED

Delivering Oncology Care to Veterans

NCODA VETERAN SUPPORT RESOURCES: SERVING THOSE WHO SERVED OUR COUNTRY

Cancer care for U.S. military veterans presents unique clinical and logistical challenges. Veterans may face higher risks for certain cancers, with health histories that include service-related exposures, post-traumatic stress and barriers to timely, coordinated oncology care.

To support oncology professionals in addressing these needs, NCODA has curated a suite of veteran-focused resources that equip clinicians with insights, education and practical tools for delivering high-quality, patient-centered care to this deserving population.

At the heart of these efforts is an understanding that veteran patients often navigate multiple healthcare systems, including the Veterans Health Administration (VHA) and community practices, and that optimized care requires both clinical expertise and systems-level coordination.

NCODA's Veteran Patient Care Resources act as a central hub where providers can access strategies for communication, treatment planning, psychosocial support, community care navigation, and survivorship planning.

Educational materials highlight the tailored approaches needed for veteran care, including best practices for managing complex health profiles and empowering patients with clear, tailored education.

Resources also address the transition from active treatment to long-term survivorship and survivorship, emphasizing the importance of patient engagement, adherence strategies and whole-health care planning.

NCODA collaborates with key stakeholders both within and outside the VHA system to expand access to clinical trials for veterans. Partnerships with organizations such as the National Association of Veterans' Research and Education Foundations help connect oncology providers and VHA investigators, enabling veterans to participate in cutting-edge research and access emerging therapies while remaining within trusted care networks.

NCODA VETERAN CARE RESOURCES

A central hub of tools and guides for clinicians caring for veteran patients:

- Veteran Care Resource Sheet
- Quick-reference guidance for community providers navigating VHA coordination and claims.
- Clinical Perspectives & Articles
- Best Practices for Patient Management in Veteran Health
- Serving Those Who Served: Delivering Oncology Care to Veterans
- Opportunity Awaits: Addressing the Unique Needs of Our Nation's Veterans

Featured Webinars and Podcasts, including:

- S7 Ep. 16: Improving Oncology Care for Veterans (PQI Podcast)
- Understanding Prostate Cancer in Veterans (Webinar)
- Overview of Advanced Prostate Cancer Management in the VA System (Webinar)

Veteran-focused perspectives and interviews further deepen understanding of care challenges and opportunities. Articles such as **Serving Those Who Served: Delivering Oncology Care to Veterans** and **Best Practices for Patient Management in Veteran Health** offer firsthand insight into the unique operational and clinical dynamics within the VHA and community settings.

NCODA also promotes awareness of advocacy opportunities, encouraging oncology professionals to engage with policymakers to help shape systems that improve timely access to care and bridge gaps between VHA and community oncology practices.

For clinicians seeking to strengthen care for veteran patients, NCODA's veteran resources provide practical, multidisciplinary guidance that respects the experiences of those who served while enhancing clinical outcomes and patient experience.

For a directory of NCODA Veteran Services, go to **www.ncoda.org/veterans**.

NCODA EDUCATIONAL VIDEOS: PRACTICAL LEARNING TOOLS FOR CLINICAL TEAMS

NCODA's educational videos provide oncology professionals with concise, practical visual guidance that can be applied directly to patient care.

Designed for multidisciplinary teams, these videos address dosing considerations, dose modifications, adverse event management, treatment surveillance, adherence strategies and clinical "pearls" that support safe, coordinated cancer treatment delivery.

Unlike traditional long-form webinars, NCODA's videos deliver focused, topic-specific insights that fit into busy clinical workflows. They are particularly useful for pharmacy staff, nurses and advanced practice providers seeking quick refreshers on specific therapies, reinforcement of best practices or onboarding to standardized procedures.

The videos are available through NCODA's online resource library and can be accessed on demand. Featured content highlights recent additions, while the broader collection allows users to sort by most recent or by topic. Many videos include clinical context and expert commentary.

HOW TEAMS USE EDUCATIONAL VIDEOS

Clinical teams use the videos for:

▲ Staff training and orientation: Standardizing knowledge on therapies and processes.

▲ Just-in-time learning: Preparing for new regimens or complex cases.

▲ Continuing education support: Reinforcing key practices alongside webinars and other training.

▲ Infusion team preparation: Reviewing setup and administration steps.

SELECT EDUCATIONAL VIDEOS

Below is a listing of several educational videos available from NCODA's library:

▲ **Akynzeo® (Ready-to-Use Vial):** A Step-by-Step Video Guide — Practical tips for administering the ready-to-use infusion vial, including tubing setup and pump programming.

▲ **BRUKINSA® (Zanubrutinib) for Relapsed or Refractory Marginal Zone Lymphoma** — Clinical and pharmacy considerations for this targeted therapy.

▲ **BRUKINSA® (Zanubrutinib) for Chronic Lymphocytic Leukemia or Small Lymphocytic Lymphoma** — Practical clinical insights.

▲ **BRUKINSA® (Zanubrutinib) for Waldenstrom's Macroglobulinemia** — Application guidance for this indication.

▲ **BRUKINSA® (Zanubrutinib) for Mantle Cell Lymphoma** — Handling, patient education and adherence considerations.

▲ **Ibrutinib-Related Cardiac Toxicities: Management & Dose Modifications** — Recognition and management of cardiovascular side effects.

▲ **Neratinib for Extended Adjuvant Treatment of Early-Stage HER2-Positive Breast Cancer (MIP)** — Expert discussion on therapy benefits and side effect strategies.

▲ **Tukysa® (tucatinib) Educational Series** — Disease overview, dosing and side effect guidance.

EXPANDING ON-DEMAND LEARNING

NCODA's video library complements webinars, PQIs and other treatment resources. Because the videos are searchable and available on demand, teams can incorporate them into training, case reviews or quality improvement initiatives. They also serve as consistent references when updating procedures or preparing for new therapy rollouts.

Whether preparing for a complex infusion, refining toxicity management or aligning on oral oncolytic best practices, NCODA's educational videos provide efficient, clinically grounded support for patient-centered oncology care.

NCODA'S ORAL ONCOLYTIC CRUSH/SUSPENSION DIRECTORY: PRACTICAL ADMINISTRATION SUPPORT

The NCODA Oral Oncolytic Crush/Suspension Directory is a clinical reference designed to help oncology teams quickly locate information on crush and suspension options for oral anticancer medications.

Swallowing difficulties are common among patients with cancer, and crushing tablets or creating a liquid suspension can be necessary for safe and effective administration in select clinical situations.

Busy clinicians often face challenges finding reliable guidance on how and when a medication can be altered for administration. The Crush/Suspension Directory consolidates current data into a single, searchable resource, giving pharmacists, nurses and advanced practice providers easy access to evidence-informed references that support individualized care planning.

Available through NCODA's online clinical resource library, the tool streamlines access to crushing and suspension guidance that might otherwise require extensive independent searching. While the directory does not cover all medications and is not a substitute for professional judgment, it helps oncology professionals make informed decisions when standard oral administration is not feasible.

A short portion of the directory is shown below. To view the full directory, go to **www.ncoda.org/crush-directory**.

Generic	Brand	Crush	Suspension	Reference
Abemaciclib	Verzenio®	No Data	• Crush tablet, disperse in at least 10 mL of water. • Administer completely and immediately within 10 minutes of dispersion.	Cohen J, Lee C, Markham R, Szerwo J, Roska M, Bubalo J. Medication use process and assessment of extemporaneous compounding and alternative routes of administration of oral oncology drugs: Guidance for clinical and oncology pharmacists. J Am Coll Clin Pharm. 2022; 5(11): 1176- 1228. doi:10.1002/jac5.1698.
Abiraterone Acetate	Zytiga®	No Data	No Data	Cohen J, Lee C, Markham R, Szerwo J, Roska M, Bubalo J. Medication use process and assessment of extemporaneous compounding and alternative routes of administration of oral oncology drugs: Guidance for clinical and oncology pharmacists. J Am Coll Clin Pharm. 2022; 5(11): 1176- 1228. doi:10.1002/jac5.1698.
Acalabrutinib	Calquence®	No Data	Tablet is dissolved in regular uncarbonated Coca-Cola.	Sharma S, Pepin X, Cheung J, et al. Bioavailability of acalabrutinib suspension delivered via nasogastric tube in the presence or absence of a proton pump inhibitor in healthy subjects. Br J Clin Pharmacol. 2022;88(10):4573-4584.doi:10.1111/bcp.15362.
Anastrozole	Arimidex®	No Data	• Place the tablet in barrel of an appropiate size and type of syringe. • Draw 10 mL of water into the syringe and allow the tablet to disperse, shaking if necessary. • May administer via feeding tube.	Cohen J, Lee C, Markham R, Szerwo J, Roska M, Bubalo J. Medication use process and assessment of extemporaneous compounding and alternative routes of administration of oral oncology drugs: Guidance for clinical and oncology pharmacists. J Am Coll Clin Pharm. 2022; 5(11): 1176- 1228. doi:10.1002/jac5.1698.
Alectinib	Alecensa®	No Data	• Empty the contents of two 150 mg alectinib capsules (300 mg) and dissolve in 40 mL pharmaceutical-grade olive oil to produce 7.5 mg/mL suspension. • Administer via PEG tube, followed by 30 ml flush of tube feeding. • A conservative expiration date of seven days.	Anderson, B. E., Luczak, T. S., Ries, L. M., Hoefs, G. E., & Silva-Benedict, A. C. (2020). Successful alectinib desensitization in a patient with anaplastic lymphoma kinase-positive adenocarcinoma of the lung and alectinib-induced drug rash. Journal of Oncology Pharmacy Practice, 26(8), 2028-2030.

ORAL ANTICANCER MEDICATION COMPASS: SUPPORTING TEAM-BASED OAM CARE

Delivering high-quality, patient-centered care to people taking oral anticancer medications (OAMs) requires more than prescribing the right drug. It demands coordinated workflows, effective patient education, standardized monitoring and clear interprofessional communication.

To help practices navigate these complexities, NCODA — in collaboration with the Oncology Nursing Society (ONS) — developed the Oral Anticancer Medication Care Compass, a tool kit designed to support interprofessional navigation of oral therapy care pathways.

Oral therapies have transformed cancer treatment, offering convenience and expanded options. They have also introduce challenges. Patients must understand dosing, monitor and report side effects, adhere to complex schedules and coordinate care across disciplines.

Without clear processes and shared tools, gaps in communication and follow-up can contribute to adverse events and reduced treatment effectiveness. The Care Compass addresses these risks by providing structured, evidence-based tools that promote consistency, teamwork and patient safety.

BUILT FOR REAL-WORLD USE

Developed jointly by NCODA and ONS, with input from pharmacists, nurses and other subject matter experts, the Care Compass is built for real-world use. It offers practical resources to assess current care processes, strengthen workflows, enhance patient education and improve outcomes through standardized practice. These tools are designed to be adaptable across practice settings, allowing teams to tailor workflows while maintaining consistent quality standards.

By aligning documentation, follow-up intervals and toxicity assessment practices, the Care Compass helps reduce variation and reinforce accountability across the care continuum. Seamless oral anticancer care depends on collaboration among pharmacy staff, clinicians, nurses, navigators and administrative teams — and the tool kit reinforces that shared responsibility.

At its core, the Care Compass supports practice assessment, patient education, toxicity oversight and adherence planning. It helps teams identify gaps, streamline transitions and align standards across settings.

Because oral therapies shift more monitoring responsibility to patients and caregivers, the Care Compass reinforces accountability and provides checkpoints that keep teams coordinated throughout treatment.

WHY THE CARE COMPASS MATTERS

The shift to oral anticancer therapies underscores the need for clearly defined interprofessional roles supported by shared tools. The Care Compass enables practices to:

- Identify workflow gaps and engage teams in quality improvement.
- Standardize patient education and consent procedures.
- Implement toxicity assessment tools to detect and manage side effects early.
- Support adherence monitoring and reinforce treatment persistence.

THE ORAL ANTICANCER MEDICATION CARE COMPASS TOOL KIT INCLUDES:

- **OAM Workflow Analysis PQI** — A structured guide to assess and optimize current oral therapy processes.
- **PQI Supplement: OAM Workflow Analysis Tool** — A practice tool developed to assess workflow gaps and to recommend improvements.
- **OAM Patient & Caregiver Education Resources** — Education guides and checklists to support communication and understanding throughout oral therapy care.
- **Assessment and Grading of Common OAM Toxicities** — A comprehensive list of common adverse events (AEs) associated with oral therapies, links to toxicity grading resources and an interactive activity for clinicians to test their knowledge in grading AEs.
- **Specialty Pharmacy and Patient Assistance Contact Directory** — Helps clinicians organize specialty pharmacy and patient assistance program contact information in one accessible resource.
- **The OAM Adherence Blueprint:** Provides the latest validated scales and strategies to assess and optimize patient adherence.

For more information on the **Oral Anticancer Medication Compass**, scan the QR code above.

NCODA Cost Avoidance & Waste Tracker

The NCODA Cost Avoidance & Waste Tracker is an online tool created to help practices document the great work they are doing saving money for patients, and showcasing the waste produced by outside vendors.

How it works:

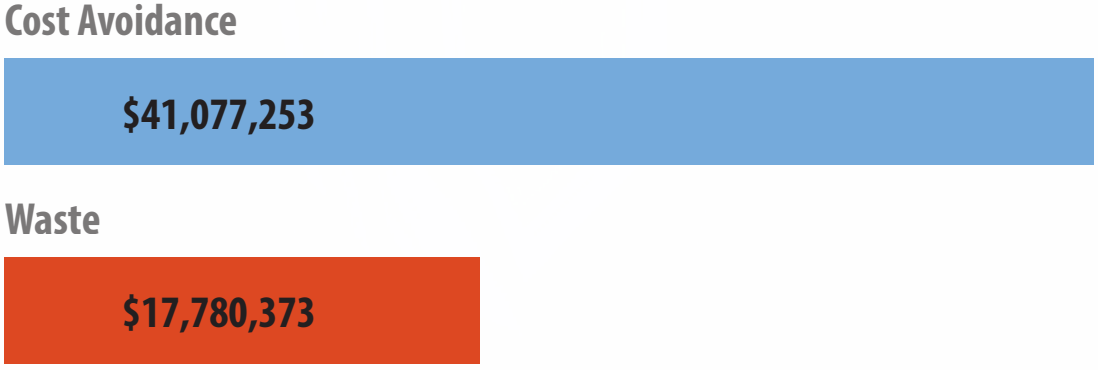
Cost Avoidance: When you intervene to prevent an unnecessary prescription, ***record the savings***.

Waste: When the patient brings in medication that was not used at all, ***record the wasted expense***.

How to use the data:

Share the information with your administration, payers, employers, and other relevant stakeholders to showcase the benefits of your practice over alternative services.

Cost Avoidance & Waste Reported *To Date* by NCODA Members



*Numbers as of March 2026

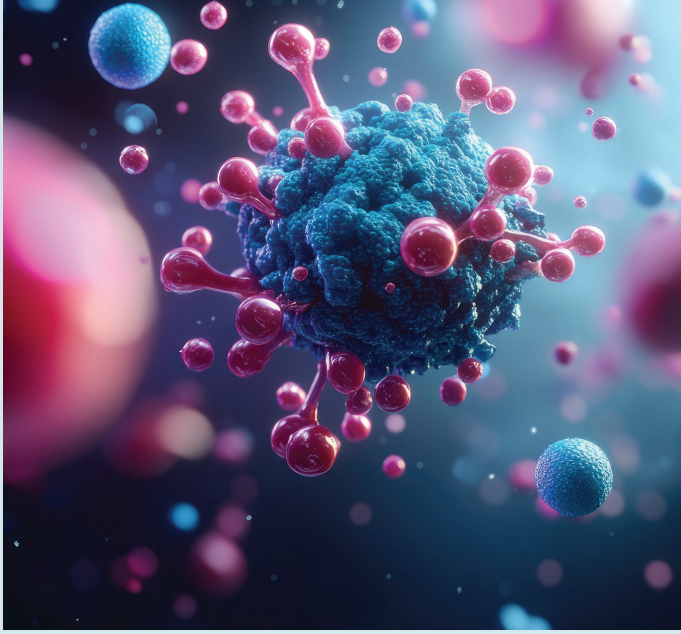
Help Us Create Change and Accountability for Healthcare Spending Nationwide!

To learn more about the tracker tool, please visit **ncoda.org/CAWT**

NCODA

IMMUNOTHERAPY HUB

Implement Bispecific Therapies with Confidence & Clarity



The NCODA Immunotherapy Hub is your go-to source for everything related to bispecific T-cell engagers (BTCEs) — whether you're taking your first steps or you're refining advanced clinical workflows. Dive into curated, practice-ready content including foundational overviews, agent-specific insights, and downloadable SOPs from real practices.

Designed for oncologists, pharmacists, nurses, and care teams in community, and academic settings alike, the Hub equips you to navigate dosing schedules, understand REMS requirements, manage adverse reactions like CRS and neurotoxicity, and adapt procedures that truly fit your practice environment.

Visit NCODA.org/Immunotherapy-Hub to access your immunotherapy roadmap now.
Empower your team. Elevate patient care.

Copay Accumulators

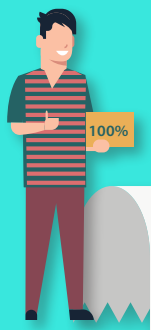
what to know & what's the difference?

Without accumulator programs

Patients with certain types of insurance can use manufacturer coupon cards to cover copays

Your Deductible

The patient's manufacturer coupon card helps to meet their deductible requirement



Once the deductible has been met, insurance begins to provide maximum coverage

RECEIPT

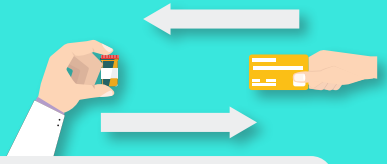
Prescription Drug Cost	$2,000.00
Manufacturer Coupon Value	-$1,995.00
Your Total at the Counter	$5.00

$2,000.00
Annual Deductible

$0.00
Remaining Deductible After Coupon*

*$2,000.00 = $5.00 paid by patient
$1,995.00 coupon

With accumulator programs



Patients can still use their coupon cards, but ...

Your Deductible

With the accumulator program, the amount paid by your coupon card would no longer count toward helping to meet your deductible

You, as the patient, will still need to pay all the money left over to reach your deductible

RECEIPT

Prescription Drug Cost	$2,000.00
Manufacturer Coupon Value	-$1,995.00
Your Total at the Counter	$5.00

$2,000.00
Annual Deductible

$1,995.00
Remaining Deductible After Coupon*

*Only $5.00 counts toward the patient's deductible and health insurers keep the $1,995.00 coupon!

VS.

An example of what happens at the pharmacy counter

NCODA

Scan QR Code To View Which States Have Active Legislation Or Enacted Laws Regarding Copay Accumulators