PQI IN ACTION

Positive Quality Intervention

NCODA

Sutimlimab-jome (Enjaymo) for the Management of Hemolysis in Cold Agglutinin Disease (CAD)

April 2026

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-world effective practices, clinical trial results, package inserts 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 Sutimlimab-jome (Enjaymo) for the Management of Hemolysis in Cold Agglutinin Disease (CAD) PQI and explores how the medically integrated teams collaborate and utilize the information found in the PQI as part of their daily practice.

Sutimlimab-jome (Enjaymo) for the Management of Hemolysis in Cold Agglutinin Disease (CAD)

PARTICIPANTS

CANCER CARE ASSOCIATES OF YORK

York, PA

Chanh Huynh, MD
Medical Oncologist

Matthew Crouse, PharmD, BCPS
Oncology Pharmacist Supervisor

Brooke Celozzi, BSN, RN
Oncology Nurse

Laura Russell, COPhT
Medication Technician

PIEDMONT CANCER INSTITUTE

Atlanta, GA

Trevor Feinstein, MD
Medical Oncologist

Michael O'Connor, PharmD
Director of Clinical Pharmacy

Adeline Chand, RN
Infusion Team Lead

Alia Shelton, CPhT
Pharmacy Technician

SUTIMLIMAB FOR COLD AGGLUTININ DISEASE

COLD agglutinin disease (CAD) is a rare autoimmune hemolytic anemia characterized by IgM autoantibodies that bind red blood cells at temperatures below 37ºC (98.6ºF) and activate the classical complement pathway. Complement activation leads to C3-mediated extravascular hemolysis in the liver and, in some cases, intravascular hemolysis.[1] CAD has an estimated prevalence of approximately 16 per one million and represents 20–30% of autoimmune hemolytic anemias. Patients commonly experience chronic anemia, fatigue, cold-induced circulatory symptoms (e.g., acrocyanosis, Raynaud phenomenon), and may require treatment intervention during acute exacerbations.[1]

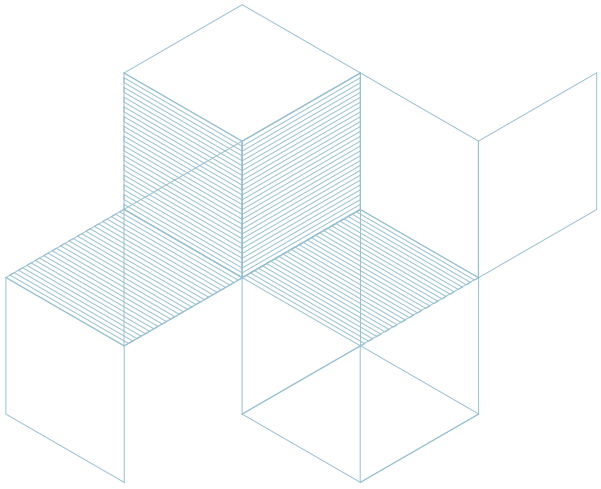
Historically, management relied on supportive care measures such as cold avoidance, folic acid supplementation, and transfusions. Rituximab and chemotherapy combination regimens have demonstrated response rates of approximately 50–60%, though responses are often partial, not durable, and associated with side effects.[1] Complement-directed therapies have emerged as a targeted strategy given the central role of classical complement activation in CAD pathophysiology.

Enjaymo® (sutimlimab-jome) is a first-in-class monoclonal antibody that selectively inhibits C1s, a serine protease in the classical complement pathway.[2] By blocking C1s, sutimlimab prevents downstream complement activation and C3-mediated hemolysis without affecting the lectin or alternative complement pathways.[2] Enjaymo is FDA-approved for the treatment of hemolysis in adults with CAD.[2]

Approval was based on two phase 3 studies, CADENZA and CARDINAL, which evaluated sutimlimab in patients with CAD. In the CARDINAL study (transfusion-dependent patients), rapid improvements in hemoglobin were observed, with the majority of patients achieving clinically meaningful increases in hemoglobin and reductions in transfusion requirements. In CADENZA (patients without recent transfusions), sutimlimab significantly improved hemoglobin levels and markers of hemolysis compared with placebo.[2] Across studies, improvements in bilirubin and fatigue were observed as early as one week after initiation, reflecting rapid complement inhibition.[1,2]

The most common adverse reactions reported in clinical trials included rhinitis, headache, hypertension, acrocyanosis, Raynaud's phenomenon, infections (including respiratory and urinary tract infections), fatigue, peripheral edema, and nausea.[2] Serious infections occurred in 15% of patients across phase 3 trials, including infections caused by encapsulated bacteria.[2] Because sutimlimab inhibits the classical complement pathway, patients must be vaccinated against encapsulated organisms (e.g., Neisseria meningitidis, Streptococcus pneumoniae, and Haemophilus influenzae type B) prior to initiation, and monitored closely for signs of infection.[2] Infusion-related reactions were reported in approximately 29% of treated patients.[2]

By directly targeting the underlying complement-mediated mechanism of hemolysis in CAD, sutimlimab represents a disease-specific therapeutic advancement, offering rapid control of hemolysis and improvement in anemia for adults living with this rare and often debilitating condition.

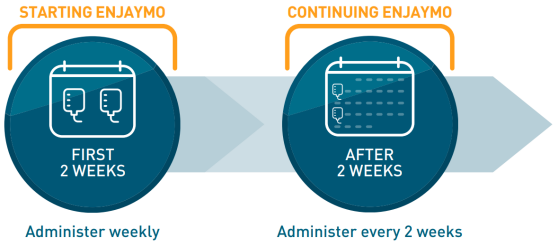


Sutimlimab for Cold Agglutinin Disease - continued

DOSING ONCE EVERY 2 WEEKS WITH ENJAYMO[2]

Dosing and administration recommendations for sutimlimab-jome[1]. May be administered as either an undiluted or diluted preparation

The recommended dosing regimen for adults with CAD consists of an initial dose and a dose 1 week later, followed by 1 dose every 2 weeks[6]



Interruptions in ENJAYMO treatment

- **If a dose is missed, administer as soon as possible and resume dosing every 2 weeks**
- **If the duration after the last dose exceeds 17 days, administer weekly for 2 weeks, with administration every 2 weeks thereafter**

Table 1: Dosing and infusion rates for **undiluted** administration

BODY WEIGHT	DOSE	VOLUME	MAXIMUM INFUSION RATE
≥39 kg to <75 kg	6,500 mg	130 mL	130 mL/hr*
≥75 kg	7,500 mg	150 mL	150 mL/hr*

Table 2: Dosing and infusion rates for **diluted** administration

BODY WEIGHT	DOSE	VOLUME OF DRUG	VOLUME OF NACL DILUENT	MAXIMUM INFUSION RATE
39 kg to <70 kg	6,500 mg	130 mL	370 mL	250 mL/hr
70 kg to <75 kg	6,500 mg	130 mL	370 mL	500 mL/hr*
≥75 kg	7,500 mg	150 mL	350 mL	500 mL/hr*

**Patients with cardiopulmonary disease may receive infusion over 120 minutes; In-line infusion warmers may be used, do not exceed a temperature of 104°F (40°C).*

❍ **For diluted administration:**

- Dilute with 0.9% Sodium Chloride Injection to a total volume of 500 mL
- Administer infusion solution only through 0.2 micron in-line filter with a polyethersulfone membrane
- Prime tubing with medication solu tion immediately prior to infusion and flush immediately following completion with ~20mL of 0.9% Sodium Chloride Injection

❍ **Slow or stop the infusion in case of infusion reaction**

❍ **Monitor patient for at least two hours after initial infusion for signs/symptoms of infusion and/or hypersensitivity reaction and for at least one hour after completion of subsequent infusions**

❍ **Administer dose based on body weight weekly for the first 2 doses then every two weeks thereafter**

❍ **If a dose is missed, administer as soon as possible; thereafter, resume dosing every two weeks. If the duration after the last dose exceeds 17 days, administer weekly for two weeks, with administration every two weeks thereafter.**

❍ **If treatment is interrupted or stopped, patients should be monitored for signs/ symptoms of recurrent hemolysis and con- sideration for resumption of therapy given:**

- Elevated total bilirubin or lactate dehydrogenase with decrease in hemoglobin
- Reappearance of symptoms such as fatigue, dyspnea, palpitations, or hemoglobinuria

❍ **Polysorbate 80 is listed as an inactive ingredient – review patient allergy list for potential cross reactivity**

HCP INSIGHTS

The teams emphasized the value of complement inhibition as a targeted and rapidly effective approach for patients with CAD, while also underscoring the importance of careful patient selection, expectation setting, and longitudinal monitoring.

Physicians described how quickly patients can respond when therapy is appropriately matched to disease biology. As Trevor Feinstein, MD explained, when the drug is the right fit, "your patient notices an improvement pretty quickly." He noted that clinicians should expect to see hemoglobin rise "rather rapidly within the first couple weeks," accompanied by normalization of hemolysis markers such as bilirubin and haptoglobin. Although lactate dehydrogenase may lag slightly, he emphasized that these parameters typically improve within weeks, reinforcing confidence that the underlying hemolytic process has been effectively interrupted.

At the same time, Dr. Feinstein highlighted the challenge of assessing symptom burden in an older population. Fatigue is common in elderly patients, making it difficult to determine how much is attributable to CAD. Rather than relying solely on laboratory values, he described a pragmatic, patient-centered approach. He often asks patients which activities they are no longer able to do and, when uncertainty remains, may err on the side of initiating treatment - "let's give it a trial." If patients feel better and hematologic parameters improve within a few weeks or months, that response helps confirm the appropriateness of treatment. If not, therapy can be discontinued without prolonged exposure.

Physicians also differentiated CAD subtypes when discussing treatment candidacy. Dr. Feinstein described three broad clinical presentations: minimally symptomatic patients who can be observed, anemic patients with active hemolysis who are strong candidates for complement inhibition, and a smaller group with predominantly acrocyanosis and red blood cell agglutination without anemia. In the latter group, he noted, complement inhibition "is not going to fix that process because it does not stop the red blood cells from sticking together," and alternative strategies such as B-cell–directed therapies may be more appropriate.

Other members of the team reinforced the durability of response with sutimlimab seen in practice. Adeline Chand, RN, described a patient who has remained on treatment with sutimlimab and continues to live an active life, including international travel. She remarked seeing a patient "live life while still undergoing treatment" has been particularly rewarding. Similarly, Michael O'Connor, PharmD noted that in his practice, sutimlimab discontinuations are rare. He shared that he more often sees new patients being added to the treatment schedule than removed.

Chanh Huynh, MD framed CAD as both rare and frequently underrecognized. He observed that with sutimlimab, "the vast majority of patients will have a prompt response," noting improvements in blood counts, hemolysis markers, and, most importantly, how patients feel. He highlighted decreasing transfusion dependence as a key clinical metric. Dr. Huynh also stressed the need for a low threshold to test for CAD, given its nonspecific symptoms, and argued that symptomatic patients may still be appropriate candidates for treatment with Sutimlimab even if anemia is well compensated. Fatigue, ongoing hemolysis, and systemic effects, he noted, can justify treatment despite near-normal hemoglobin levels.

Beyond hemolysis, Dr. Huynh underscored the broader disease burden, describing CAD as an autoimmune process with vascular manifestations and increased thrombotic risk. He cautioned clinicians to remain vigilant for associated lymphoproliferative disorders, particularly if a patient fails to respond or loses response over time, noting that reassessment for an alternate or evolving diagnosis is essential.

Finally, Matthew Crouse, PharmD, BCPS emphasized the therapeutic advance represented by complement-targeted treatment. Compared with older strategies such as chemotherapy aimed at B cells, he highlighted the "rapid improvement in symptoms" and avoidance of many downstream risks. While some patients may still cycle through other therapies first, he viewed having an additional mechanism of action as a meaningful expansion of options, particularly for patients with refractory disease or persistent symptoms.

Taken together, these insights reflect a shared clinical perspective. Complement inhibition offers rapid, tangible benefits for appropriately selected patients with CAD, while thoughtful assessment of symptoms, education around logistics, and ongoing diagnostic vigilance remain central to optimizing outcomes.

> "When the drug is the right fit, your patient notices an improvement pretty quickly. You see the hemoglobin rise within weeks, the hemolysis markers normalize, and most importantly, they start to feel better."
>
> – Trevor Feinstein, MD

COORDINATED AT THE CORE: MULTIDISCIPLINARY ONCOLOGY CARE AND MEDICALLY INTEGRATED PHARMACY

CARE for patients with rare hematologic conditions is inherently complex, often extending well beyond diagnosis and drug selection alone. At Cancer Care Associates of York and Piedmont Cancer Institute, clinicians and staff emphasized that optimal outcomes depend on a multidisciplinary oncology team working in close coordination. This model brings together physicians, nurses, pharmacists, schedulers, financial specialists, and support staff to address not only clinical decision-making, but also the logistical, operational, and social factors that influence a patient's ability to remain on therapy.

Rather than functioning as a series of handoffs, multidisciplinary care was consistently described as an integrated system in which responsibilities overlap and communication is continuous. Laura Russell, COPhT reflected on how much of the complexity is intentionally managed behind the scenes, noting how fortunate her team is to have dedicated departments handling infusion coordination, prior authorizations, financial assistance, and manufacturer support. Because these functions are embedded into the care pathway, she explained, they do not fall to individual clinicians or patients. She shared, "it doesn't go past me that we are very lucky to have that."

This shared infrastructure allows each discipline to focus on its area of expertise while remaining aligned around the patient's overall plan of care. Nurses, for example, serve as critical connectors across the team. Brooke Celozzi, BSN, RN described coordinating closely with providers to determine dosing needs, with schedulers to ensure visits are timed appropriately, and with billing teams to help address practical barriers such as transportation. She also emphasized the importance of routine laboratory monitoring and standing protocols to identify early signs of complications, reduce hospital admissions, and prevent avoidable transfusions, particularly in outpatient settings where supportive resources may be limited.

Physicians underscored that this level of coordination is essential rather than optional. Dr. Huynh described multidisciplinary collaboration as "absolutely necessary," noting that most aspects of patient care touch multiple disciplines. Comprehensive, holistic care, he explained, requires ongoing outreach to colleagues across the system so that complexity is shared rather than managed in isolation.

Within this broader team-based framework, the medically integrated pharmacy plays a central and enabling role. Pharmacy integration allows treatment planning, laboratory review, scheduling, and medication preparation to function as a single coordinated process rather than separate steps. Crouse described how pharmacists work closely with schedulers and providers to ensure labs are drawn days in advance, treatment is approved in a timely manner, and medications are ordered only when therapy is confirmed. This approach supports patient safety, reduces delays, and minimizes drug waste. As he noted, "we all work together" to ensure that care proceeds smoothly.

Together, these perspectives highlight how multidisciplinary oncology teams create the foundation for effective care delivery, with medically integrated pharmacy embedded at the core of that system. By aligning clinical decisions, operational workflows, and patient support, this model enables complex therapies to be delivered reliably while keeping the patient experience front and center.

PHYSICIAN LEADERSHIP: ANCHORING CARE WITHIN A MULTIDISCIPLINARY SYSTEM

Physicians described their role as extending beyond diagnosis and treatment selection to include leadership and coordination within a multidisciplinary oncology team. In community settings, hematologist-oncologists often serve as both clinical decision-makers and organizational stewards, helping align patient care with research, operations, and value-based initiatives.

Dr. Feinstein highlighted the breadth of this responsibility, noting that alongside his clinical practice, he holds multiple leadership roles across research and network-wide oncology programs.

Coordinated at the Core: Multidisciplinary Oncology Care and Medically Integrated Pharmacy - continued

Dr. Huynh similarly described a blended clinical and administrative role shaped by long-term practice in a community oncology setting. In addition to caring for patients as a hematologist-oncologist, he is involved in research, value-based care, and pharmacy and therapeutics oversight. This involvement reflects how physicians help guide formulary decisions and treatment strategies that balance clinical benefit with system sustainability.

THE PHARMACIST'S ROLE IN MEDICALLY INTEGRATED ONCOLOGY CARE

Within a multidisciplinary oncology model, the pharmacist plays a critical role in operationalizing treatment decisions. Pharmacists described their work as essential to ensuring that therapies are built correctly in the EMR, delivered safely, and supported by appropriate clinical, operational, and financial infrastructure.

O'Connor described his role as spanning nearly all non-retail pharmacy functions. As Director of Clinical Pharmacy, he is responsible for regimen development, dispensing system maintenance, and the addition of new therapies. Regimen builds are developed in close collaboration with physicians and nursing leadership, with pharmacy reviewing protocols from a medication and safety perspective before they are finalized and approved.

These roles position physicians to influence not only individual treatment decisions, but also broader care pathways and institutional priorities.

Crouse echoed this integrated approach, describing responsibility for infusion services, inventory management, USP 800 compliance, and leadership of the pharmacy and therapeutics committee. He also works closely with clinical teams on protocol maintenance and provides operational and financial recommendations tied to treatment decisions, while overseeing medication technicians who support infusion preparation.

NURSING: ENSURING SAFETY AT THE POINT OF CARE

Nurses detailed their role as central to safeguarding treatment delivery through real-time communication and structured safety checks. Positioned at the point of infusion, nursing teams serve as the final clinical checkpoint before therapy is administered.

Chand emphasized the importance of close communication with providers, noting that when questions arise, nurses address them immediately, often "in real time while the patient's sitting in the chair." This ensures that any safety concerns are resolved before treatment proceeds. She also highlighted the multiple double-checks embedded in the workflow.

Nursing is a critical safeguard within the multidisciplinary oncology team, reinforcing accuracy, consistency, and patient safety at every infusion. It is the connective layer that ensures protocols are applied consistently while remaining responsive to individual patient needs. By combining clinical monitoring with patient-centered education and coordination, nurses help reduce avoidable complications and support continuity of care throughout treatment.

PHARMACY TECHNICIANS: SUPPORTING SAFETY, FLOW, AND TEAM-BASED CARE

The Pharmacy Technician role is essential to the day-to-day functioning of medically integrated oncology care. Working alongside pharmacists and nurses, technicians help ensure that medications, supplies, and workflows are aligned so treatment can proceed safely and without delay.

Russell, a certified oncology pharmacy technician supporting infusion services, emphasized the behind-the-scenes nature of the role. She described how they support nurses by managing inventory and ensuring that everything needed in the mixing room is available and organized. She noted that specialization allows each person to focus on their area of expertise, reducing burden across the team. She described her role as being the nurses' "right or left hand," emphasizing how technician support creates a ripple effect that ultimately benefits patients.

Alia Shelton, CPhT echoed the emphasis on precision and safety. Her responsibilities include managing inventory of specialized medications, supporting sterile and non-sterile preparation, and performing quality assurance checks. As she noted, technician work directly impacts patient safety and treatment effectiveness.

> "A lot of our care touches multiple disciplines. Having that comprehensive, holistic care for our patients is absolutely necessary."
>
> – Chanh Huynh, MD

PQI PROCESS AND WORKFLOW:
FROM ORDER TO INFUSION

ACROSS sites, the PQI process was characterized as a highly structured, team-driven workflow designed to ensure that complex therapies move safely and predictably from order initiation to infusion. Rather than a single handoff, care delivery unfolds as a sequence of coordinated steps involving pharmacy, nursing, scheduling, and providers, with each role reinforcing accuracy, timing, and patient readiness.

On the pharmacy operations side, workflow begins well before the patient arrives. Russell described how pharmacy technicians are responsible for order receipt and inventory control, including verifying that sutimlimab is received, stored, and maintained at appropriate temperatures. "It starts at baseline making sure that we get the drug and it's at the right temperature," she explained. Medications are monitored in controlled storage environments, inspected prior to preparation, and tracked against the treatment schedule to ensure availability on the day of infusion. Sutimlimab should be refrigerated at 36 °F to 46 °F (2 °C to 8 °C) in the original carton to protect from light. It should not be frozen or shaken.[2]

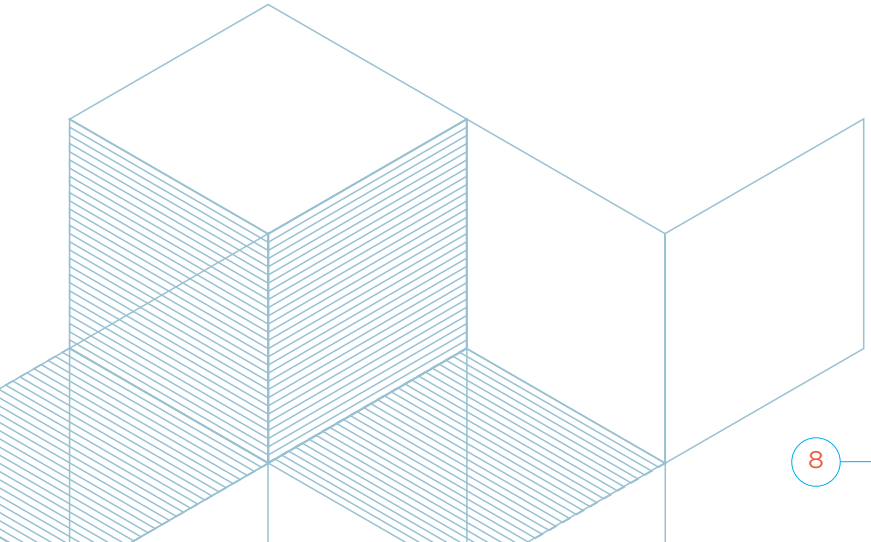
As treatment approaches, pharmacists and technicians work together to confirm that patients meet treatment criteria. Russell noted that pharmacists review laboratory values to ensure patients are appropriate for therapy, after which technicians manage downstream preparation tasks. These include verifying supplies, confirming the correct solution and tubing, maintaining antimicrobial controls, labeling infusion bags, and coordinating double checks with nursing staff.

Both practices highlighted the importance of advance planning to prevent delays. Shelton explained that medications are typically ordered several days in advance, ensuring that product is on hand before the patient arrives. This proactive ordering allows teams to avoid last-minute disruptions and supports a smoother treatment day. Crouse echoed this sequencing, describing how providers select doses within standardized order sets, pharmacists confirm accuracy, and patients are weighed and assessed prior to treatment to determine whether dose or rate adjustments are needed.

Patient-facing workflow is similarly structured. Chand described a standardized onboarding process for new patients that begins with one-on-one nurse education. During these sessions, nurses review the drug, anticipated side effects, monitoring requirements, and symptoms that should prompt outreach to the care team. Patients also have an opportunity to meet with a provider to address diagnosis-specific or prognostic questions before proceeding to infusion. As Chand summarized, the process follows a clear progression: education, office visit, then infusion.

Coordination across roles continues on the day of treatment. Crouse described how nurses complete assessments to confirm readiness, while medication technicians manage workflow in the mixing room by pulling drugs, preparing supplies, and triaging the schedule. Once the patient is cleared to treat, pharmacy-prepared medications are finalized and administered. When communication is clear, he noted, "it is a smooth process."

Several team members underscored the importance of expectation setting, particularly when workflows differ from more familiar infusion experiences. O'Connor noted that certain preparation requirements can cause delays in the process, which may cause patient anxiety if not explained in advance. Clear communication about timing and preparation steps helps maintain patient confidence and supports a positive infusion experience.



FROM PLANNING TO PROTECTION: VACCINATION AS PART OF THE PQI

WITHIN the PQI process, vaccination is treated as an essential safety step rather than a parallel or optional task. Clinicians emphasized that immunization planning is embedded into treatment initiation for patients starting complement inhibitor therapy, with shared responsibility across physicians, pharmacy, and nursing teams.

When feasible, patients are vaccinated at least two weeks prior to starting therapy to allow for an adequate immune response. If treatment must begin urgently, vaccination is administered as soon as possible and incorporated into ongoing monitoring and follow-up.

Vaccination decisions are guided by Advisory Committee on Immunization Practices (ACIP) recommendations specific to complement inhibitor therapy, which may differ from standard adult vaccine guidance. These recommendations focus on protection against meningococcal and pneumococcal disease, with vaccine selection and timing informed by prior vaccination history and anticipated duration of treatment.

Operationally, vaccination status is reviewed during treatment planning and reassessed over time. Providers confirm clinical appropriateness, nurses support education and administration, and pharmacy teams assist with documentation, timing, and longitudinal tracking. By embedding vaccination into the broader PQI workflow rather than treating it as a one-time task, care teams support patient safety and continuity of care as therapy begins and continues.

From a clinical standpoint, vaccination is prioritized early. Dr. Feinstein summarized the guiding principle succinctly: "Vaccinate before you start treatment." He explained that patients should receive vaccines against encapsulated bacteria as soon as possible, ideally prior to therapy initiation. At the same time, he acknowledged the realities of clinical urgency, noting that "if someone is urgent to get started on treatment, you can vaccinate after treatment has been started." This flexibility allows teams to balance infection risk with the need to promptly control disease.

Pharmacy plays a central role in operationalizing this guidance. O'Connor defined vaccination as a built-in component of the treatment regimen, explaining that "we would add vaccinations on. That is part of the regimen." Beyond initial scheduling, he described an ongoing monitoring function, periodically reviewing patients on therapy to ensure vaccination status remains current. He pays particular attention to longer-term booster requirements, noting that when patients approach key milestones such as one year or five years on therapy, "that is where I will often put eyes on it."

This longitudinal oversight often requires proactive communication. Because treatment regimens are typically built for a defined time frame, O'Connor explained that pharmacy may need to re-engage providers when additional vaccines or boosters are due. Crouse echoed this responsibility, describing vaccination tracking as part of ongoing regimen oversight. He emphasized pharmacy's role in preventing infections associated with encapsulated bacteria through vigilance and documentation.

Nursing teams provide another critical checkpoint. Celozzi described ensuring vaccination completion as part of readiness to treat, particularly before first-dose administration. "Before I give them their drug, especially the first dose, I make sure that they have their vaccines completed," she explained. This verification is tied closely to patient education and safety monitoring. Celozzi also highlighted the importance of reinforcing why vaccination is prioritized, particularly meningococcal and pneumococcal immunization, so patients understand its role in reducing infection risk during therapy.

Dr. Huynh shared that vaccination coordination is inherently multidisciplinary. He described how, once the decision to initiate therapy is made, teams "partner" with pharmacy to confirm that patients are up to date on required vaccines. He noted that his practice has formalized this process, with pharmacy maintaining clear vaccination lists and collaborating with primary care colleagues when vaccines are administered outside the oncology clinic. This additional touch point helps ensure timely vaccination without delaying treatment.

From Planning to Protection: Vaccination as Part of the PQI - continued

PQI PROCESS:

01 Vaccination against encapsulated bacteria should take place at least 2 weeks prior to initiation of sutimlimab-jome. If urgent therapy is indicated, administer vaccines as soon as possible[2]

02 Advisory Committee on Immunization Practices (ACIP) recommendations for patients on complement inhibitor therapy (may differ from adult recommendations in vaccine package inserts):[5*]

03 Meningococcal vaccine

- MenACWY: 2 dose primary series with either Menveo or MenQuadfi at least 8 weeks apart, 1 booster dose 5 years after primary series and every 5 years if remaining on treatment
- MenB: Bexsero or Trumenba (use same brand for all doses including booster doses)
  - Primary series: 3 doses at 0, 1-2, 6 months (if dose 2 administered at least 6 months after dose 1, dose 3 not needed; if dose 3 is administered earlier than 4 months after dose 2, a 4th dose should be administered at least 4 months after dose 3)
  - Booster doses:1 booster dose one year after primary series and every 2-3 years if remaining on treatment
  - MenACWY-TT/MenB-FHbp: May receive a single dose of Penbraya as an alternative to separate administration of MenACWY and MenB when both vaccines would be given on the same clinic day. Penbraya may be used for booster doses if at least 6 months have elapsed since most recent dose.

04 Pneumococcal vaccine

- Not previously received a PCV13, PCV15, PCV20, or PCV21 or whose previous vaccination history is unknown: 1 dose PCV15, PCV20, or PCV21
  - If PCV15 is given, administer 1 dose PPSV23 at minimum interval of 8 weeks after the PCV15 dose
- Previously received PCV7: same recommendation as above
- Previously received PCV13: 1 dose PCV20 or PCV21 at least 1 year after PCV13 dose
- Previously received PPSV23: 1 dose PCV15, PCV20, or PCV21 at least 1 year after the last PPSV23
- Previously received PCV13 and 1 dose of PPSV23: 1 dose PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose (if additional PPSV23 received at age 65 or older, based on shared clinical decision making can receive this booster at least 5 years after the last pneumococcal vaccine dose)

*Check ACIP website for updates

ADVERSE EVENT MANAGEMENT:

STRUCTURED MONITORING AND CLINICAL VIGILANCE

ADVERSE event management is proactive and multidisciplinary, combining standardized safety protocols with ongoing clinical assessment. While sutimlimab is generally well tolerated, clinicians emphasized the importance of monitoring for infection risk, potential autoimmune manifestations, and infusion reactions.

Because complement inhibition increases susceptibility to infections, teams watch for signs of respiratory, urinary tract, and other bacterial infections. Monitoring also includes awareness of potential autoimmune conditions, such as systemic lupus erythematosus, with attention to joint pain or swelling, facial rash, and unexplained fever.

In clinical practice, physicians characterized most adverse effects as manageable. Dr. Feinstein noted that side effects "usually tend to be fairly well tolerated," with occasional mild hypertension. The most common issue he observes is rhinitis, describing it as "kind of a runny nose. It is mild. It is usually very manageable." Importantly, many patients report improvement in fatigue after starting therapy and "actually feel much better." When patients present with acute or concurrent illness, however, he emphasized the importance of careful risk–benefit evaluation and maintaining a low threshold for antibiotics when appropriate.

Infusion-related reactions, reported in approximately 29% of patients in pooled clinical trial data, are addressed through predefined emergency order sets and treatment algorithms.[2] O'Connor described close collaboration between nursing, pharmacy, and physicians when reactions occur. Nurses may call to discuss whether to slow the infusion or add premedications, after which he coordinates regimen adjustments and communicates changes to the care team. "I typically put a note in on the regimen," he explained, flagging rate modifications to ensure consistency at subsequent cycles.

Beyond acute reactions, ongoing monitoring focuses on treatment effectiveness and disease control. Crouse described routinely tracking hemoglobin, bilirubin, and LDH, alongside objective symptoms such as fatigue and dyspnea. If laboratory values fail to improve or worsen despite adherence to therapy, teams reassess the diagnosis. As he noted, when patients are not responding as expected, "something else is going on," and further investigation is warranted.

PATIENT EDUCATION:

SETTING EXPECTATIONS AND REINFORCING SAFETY

PATIENT education begins at diagnosis and continues throughout treatment. Teams described education that is both conversational and structured, ensuring patients understand their condition, the purpose of therapy, and the practical realities of treatment.

Dr. Feinstein starts with a foundational discussion at the time of diagnosis. "Usually when we make this diagnosis, I will sit down with the patient and explain what it is," he noted, underscoring the importance of grounding patients in a clear understanding of disease biology before introducing therapy.

At Cancer Care Associates of York when a provider recommends a new therapy, patients receive a standardized education session with a nurse reviewing dosing schedules, anticipated side effects, and monitoring requirements. This session ensures patients understand what to expect before they arrive for infusion.

Chand described education as both verbal and written. Nurses review materials in person and provide printed resources outlining symptoms that warrant a call to the clinic. "If you experience this,

Patient Education: Setting Expectations and ReinforcingSafety - continued

call us," she said, noting that guidance includes detailed instructions related to infection, or other concerning symptoms. Patients are specifically counseled to seek immediate medical attention for signs of serious infection, including fever, severe headache, confusion, neck or back stiffness, body aches, or light sensitivity.

Practical logistics are also addressed upfront. Patients are informed that infusion visits may last approximately two to four hours, depending on rate and monitoring requirements. They are counseled on the importance of completing vaccination schedules, ideally at least two weeks prior to therapy initiation, and are educated about adherence to dosing intervals. If a maintenance dose is missed by more than three days, patients may need to return to weekly dosing for 2 weeks and continue biweekly dosing after the loading dose, reinforcing the importance of timely attendance.

Importantly, education extends beyond logistics to disease understanding. Celozzi described explaining cold agglutinin disease in accessible terms, telling patients that their "body doesn't like cold," and that exposure can trigger destruction of red blood cells. She explains that therapy works by preventing that mechanism, helping keep the disease in a controlled or remission-like state rather than allowing the immune system to "constantly attack itself." The teams also reinforce that cold agglutinin disease is a chronic condition requiring ongoing therapy and continuous monitoring.

Even when hemoglobin levels improve and laboratory markers normalize, the underlying disease persists. Patient education should emphasize that improvement does not mean resolution, and that adherence, routine monitoring, and continued engagement with the care team remain essential to prevent relapse and maintain long-term disease control.

Together, these educational touchpoints ensure patients are informed, prepared, and empowered. By combining physician-led diagnosis discussions, structured nursing and pharmacy education sessions, clear written materials, and ongoing reinforcement at each visit, the PQI process supports patient engagement while strengthening safety and adherence throughout treatment.

PATIENT EDUCATION AT A GLANCE

01 **Do patients understand their diagnosis?** Clear explanation of disease mechanism and how therapy works.

02 **Are vaccinations completed?** Ideally at least two weeks prior to initiation.

03 **Do patients have written resources?** Printed materials provided to reinforce verbal education.

04 **Are treatment expectations clear?** Infusion and observation time (approximately 2–4 hours), monitoring, and visit flow reviewed.

05 **Do patients know when to call?** Immediate evaluation for fever, severe headache, confusion, neck or back stiffness, light sensitivity, or other signs of serious infection.

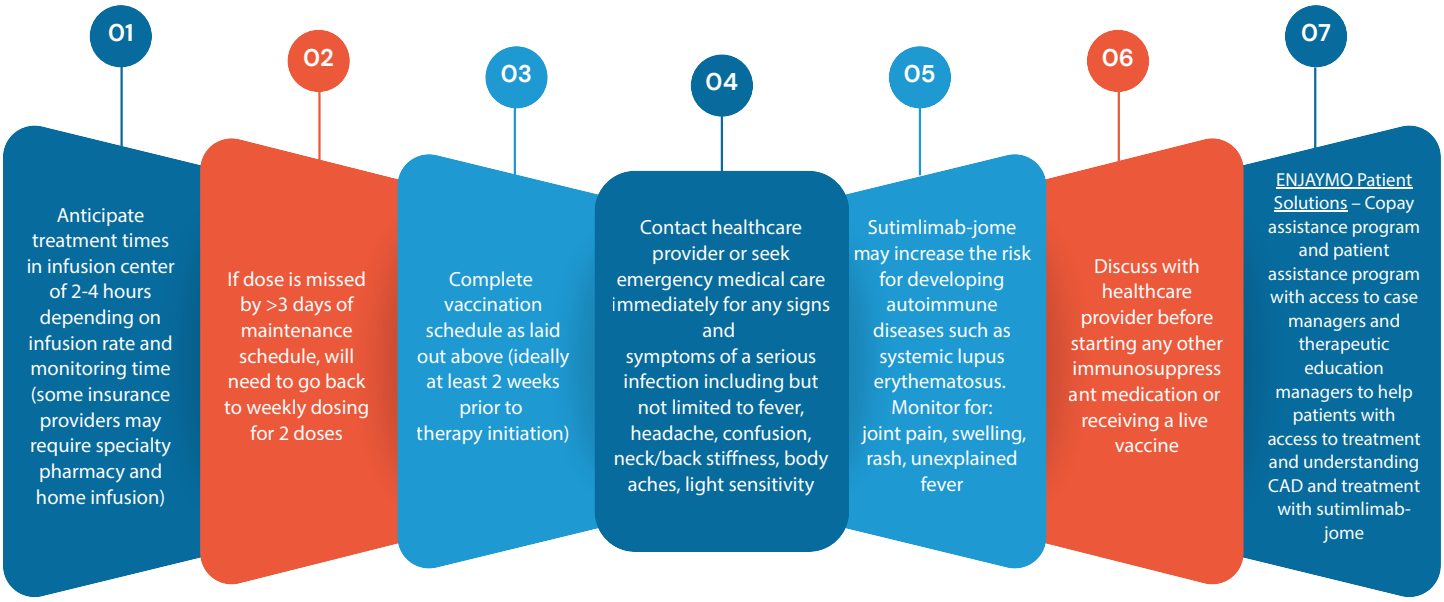
06 **Is the dosing schedule understood?** Maintenance every two weeks; if delayed by more three days of planned schedule or more than 17 days after prior infusion, return to weekly for 2 weeks and continue biweekly dosing after.

Patient Education: Setting Expectations and ReinforcingSafety - continued

MONITORING AT A GLANCE

01	**Are vaccinations up to date?** Initial series completed and boosters scheduled as indicated.
02	**Was the infusion tolerated?** No significant reactions requiring rate adjustment or added premedication.
03	**Are labs improving?** Hemoglobin, bilirubin, LDH, and transfusion requirements trending appropriately.
04	**Are symptoms improving?** Fatigue, dyspnea, and functional status reflecting disease control.
05	**Any signs of infection?** Fever, respiratory or urinary symptoms, or other concerning findings.
06	**Is the patient on schedule?** Avoid delays; consider reloading if treatment is delayed beyond 17 days.

PATIENT-CENTERED ACTIVITIES[6]



THE VALUE OF SHARED LEARNING

TEAMS shared that the value of NCODA's PQI lies in shared learning and practical implementation guidance. Russell noted that seeing how other practices approach care often sparks new ideas. "We are all in the oncology field," she said, and learning from different team perspectives can drive meaningful improvements for patients.

Dr. Feinstein reflected on the early days of adoption, when introducing a new therapy required reassurance and education across centers. "It was a lot of hand holding," he recalled, particularly in a rare disease where many clinicians have limited exposure. As experience grows, structured resources such as PQI, help reinforce confidence and consistency in care delivery.

From the pharmacy perspective, O'Connor highlighted the benefit of having consolidated, actionable information readily available, particularly around vaccination requirements and workflow considerations. Having guidance "right there" streamlines implementation and reduces uncertainty.

CONCLUSION

THE success of therapy in rare hematologic disease does not rest on the drug alone. It depends on the alignment of scientific innovation, structured guidance, and coordinated multidisciplinary execution. When the therapy, NCODA's PQI framework, and an integrated oncology team work in concert, complexity becomes manageable and patient-centered care becomes both achievable and sustainable.

SUTIMLIMAB CARE TEAM CHECKLIST[1-5]

Pre-Initiation

- Confirm diagnosis of cold agglutinin disease (CAD) and indication for sutimlimab-jome
- Obtain baseline labs (hemoglobin, bilirubin, LDH, markers of hemolysis)
- Assess and update vaccination status for encapsulated organisms
- Complete vaccinations at least 2 weeks prior to initiation when feasible
- Review allergy history, including polysorbate 80
- Educate patient on chronic nature of CAD, ongoing therapy, and infection risk

Infusion Day

- Verify patient weight for appropriate dosing (6,500 mg or 7,500 mg)
- Confirm preparation (diluted vs undiluted) and infusion rate per protocol
- Ensure appropriate filter and administration technique if diluted
- Monitor for infusion-related or hypersensitivity reactions
- Observe patient for appropriate post-infusion monitoring time

Ongoing Therapy

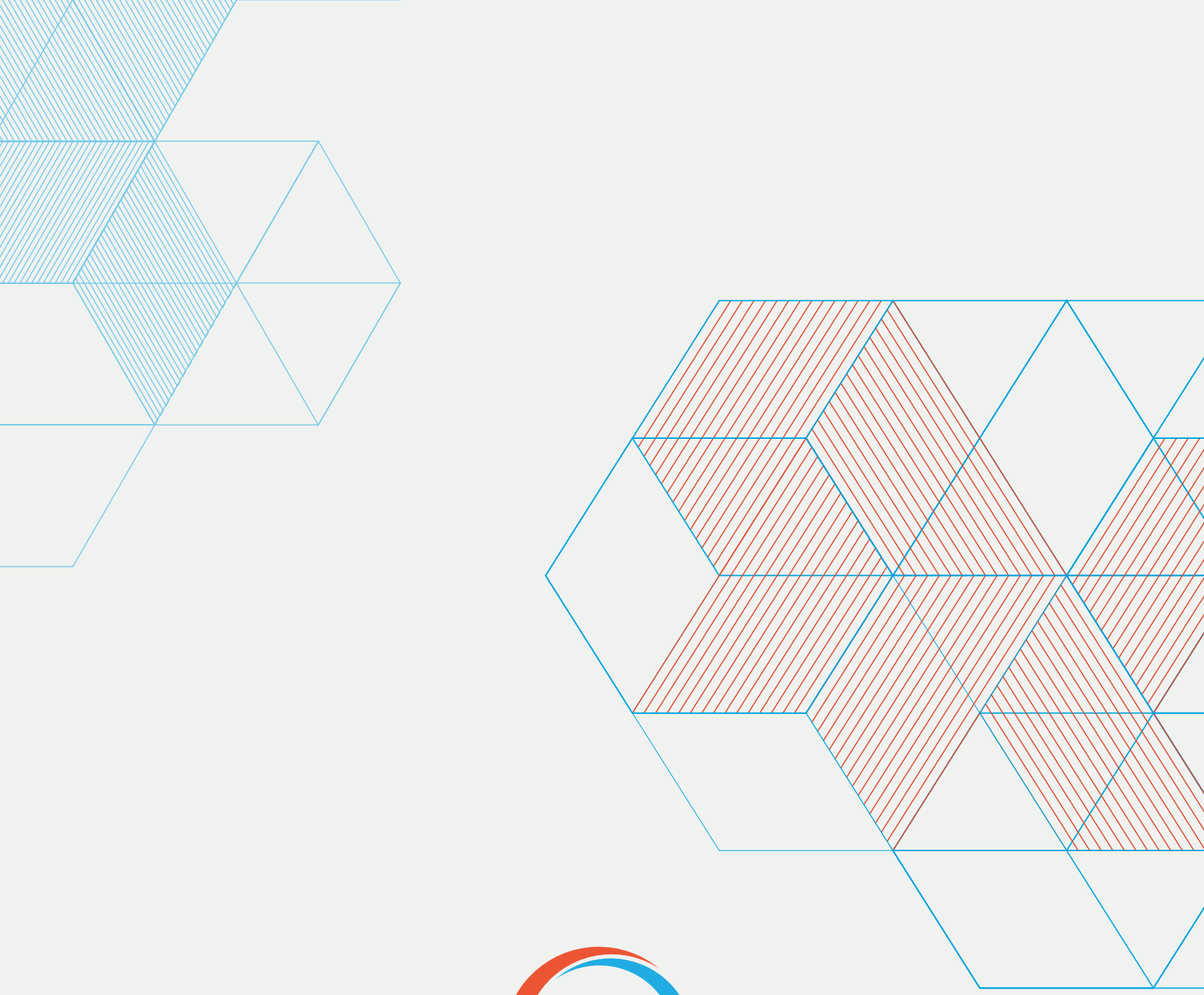
- Monitor lab trends (hemoglobin, bilirubin, LDH) to assess response and detect hemolysis
- Assess for recurrence of symptoms (fatigue, dyspnea, hemoglobinuria)
- Maintain dosing schedule (every 2 weeks after initial loading doses)
- Ensure completion of vaccination series and appropriate booster doses
- Conduct ongoing infection surveillance due to complement inhibition
- Reinforce patient education: CAD is chronic, therapy is ongoing, monitoring continues even when labs improve

Interruption or Discontinuation

- If dose missed, administer as soon as possible and resume every 2-week dosing
- If >17 days since last dose, administer weekly for 2 doses, then resume every 2 weeks
- Monitor for recurrent hemolysis (increased bilirubin or LDH, decreased hemoglobin, return of symptoms)
- Reassess need for therapy re-initiation
- Maintain close follow-up and patient engagement
- If patient is traveling for a longer duration coordinate care/infusions in other states in collaboration with HCPs treating CAD/infusion centers

REFERENCES:

1. Barcellini W, Fattizzo B. The evolving management algorithm for the patient with newly diagnosed cold agglutinin disease. Expert Rev Hematol. 2024;17(7):287-294. doi:10.1080/17474086.2024.2366540
2. Recordati Rare Diseases Inc. ENJAYMO (sutimlimab-jome) injection, for intravenous use. Prescribing information. Revised June 2025. Accessed February 20, 2026.
3. Röth A, Barcellini W, D'Sa S, et al. Sutimlimab in Cold Agglutinin Disease. New England Journal of Medicine. 2021;384:1323–1334. doi:10.1056/NEJMoa2027760.
4. Röth A, Berentsen S, Barcellini W, et al. Sutimlimab in patients with cold agglutinin disease: results of the randomized placebo-controlled phase 3 CADENZA trial. Blood. 2022;140(9):980–991. doi:10.1182/blood.2021014955.
5. Adult Immunization Schedule Notes. Centers for Disease Control and Prevention. Updated July 2, 2025. Accessed September 12, 2025. https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-notes.html.
6. Enjaymo website. https://www.enjaymo.com.



Practice panelist's comments reflect their experiences and opinions and should not be used as a substitute for medical judgment.

Important notice: NCODA has developed this Positive Quality Intervention in Action platform. This platform represents a brief summary of medication uses and therapy options derived from information provided by the drug manufacturer and other resources. This platform is intended as an educational aid and does not provide individual medical advice and does not substitute for the advice of a qualified healthcare professional. This platform does not cover all existing information related to the possible uses, directions, doses, precautions, warning, interactions, adverse effects, or risks associated with the medication discussed in the platform and is not intended as a substitute for the advice of a qualified healthcare professional. The materials contained in this platform are for informational purposes only and do not constitute or imply endorsement, recommendation, or favoring of this medication by NCODA, which assumes no liability for and does not ensure the accuracy of the information presented. NCODA does not make any representations with respect to the medications whatsoever, and any and all decisions, with respect to such medications, are at the sole risk of the individual consuming the medication. All decisions related to taking this medication should be made with the guidance and under the direction of a qualified healthcare professional.