

Community Cancer Centers Working With CAR-T Centers

Referral, bridging therapy, communication, transition, and long-term monitoring toolkit

THE OPERATING PRINCIPLE

One patient. Two sites. One current plan. Every task has a named owner, deadline, confirmation method, and escalation route.

What this toolkit includes

- Early referral triggers and a closed-loop referral packet
- Phase-by-phase responsibility matrix
- Communication compact and milestone update template
- Joint bridging-therapy plan and paired safety checklist
- Pre-infusion and return-to-community checklists
- Post-CAR-T monitoring schedule and urgent escalation guide
- Shared quality measures and case-review prompts

Important

Adapt to current product labeling, accreditation standards, payer rules, and local policy. This resource supports—not replaces—clinical judgment or treatment-center direction.

1. Build the Shared-Care Relationship Before the First Referral

WHY IT MATTERS

Delays, unclear ownership, and incomplete records can cost eligibility. A standing partnership lets the community team refer earlier, maintain disease control, and resume appropriate care after the acute CAR-T period.

Shared-care compact

Both sites agree to	Minimum standard	Local decision / owner
Named contacts	Clinical, nursing, pharmacy, financial/access, scheduling, and after-hours contacts at both sites.	
Closed-loop communication	Every request is acknowledged; urgent issues use a live route, not portal-only messaging.	
One medication plan	No anticancer therapy, steroid, immunosuppressant, prophylaxis, or interacting drug is started/stopped without the designated review process.	
Milestone updates	Referral accepted; consult decision; apheresis; product status; bridging start/stop; lymphodepletion; infusion; discharge; transition; response.	
Document exchange	A defined method for pathology, imaging, labs, notes, medication lists, toxicity grades, transfusion history, and authorizations.	
Escalation rules	Who to call, expected response, emergency destination, transfer process, and backup when the primary route fails.	

Contact directory

Function	Community center	CAR-T center	Primary / backup / hours
Physician/APP			
Nurse coordinator			
Pharmacist			
Scheduling/access			
Social work			
24/7 urgent line			
Transfer center / ED			

2. Refer Early: Triggers and Minimum Packet

Early referral gives time to confirm eligibility, arrange apheresis and manufacturing, address access barriers, and plan disease control. Outpatient and community implementation literature consistently emphasizes multidisciplinary coordination, caregiver/logistics assessment, and reliable escalation pathways.¹⁻⁴

Referral triggers—do not wait for all boxes to be checked

- Patient approaches a disease- and product-relevant line of therapy or has high-risk relapse/refractory disease.
- Disease tempo suggests that another full line of therapy could narrow the treatment window.
- Organ function, performance status, cytopenias, infection, or tumor burden could worsen with delay.
- The patient needs early insurance, travel, lodging, caregiver, fertility, language, or psychosocial planning.
- There is uncertainty about candidacy: request a center opinion instead of assuming ineligibility.

Closed-loop referral checklist

Community	Send / document	CAR-T center	Confirm / act
☐	Diagnosis, pathology, target expression/molecular studies, stage, current disease sites	☐	Review completeness; request missing items
☐	Treatment timeline, doses, responses, refractory status, toxicities, transplant/cellular history	☐	Confirm likely indication and next-step timing
☐	Recent imaging and marrow/CSF studies as relevant; actual images available	☐	Confirm receipt and radiology access
☐	CBC/differential, CMP, LDH and disease-specific labs; trends included	☐	Identify urgent organ-function/cytopenia issues
☐	Performance/functional status, comorbidities, infection history, neurologic baseline	☐	Define additional workup/consults
☐	Medication/allergy list, antimicrobial prophylaxis, anticoagulation, steroids	☐	Flag collection/bridging/interaction concerns
☐	Insurance/authorization status and patient preference	☐	Assign financial/access owner
☐	Caregiver, transportation, distance, lodging, communication and language needs	☐	Assign mitigation plan
☐	Referrer's urgency and proposed interim treatment	☐	Return consult date and “what to do while waiting” plan

REFERRAL IS COMPLETE ONLY WHEN

The CAR-T center confirms receipt, assigns a clinical owner, provides the next milestone/date, and returns an interim disease-management instruction.

3. Who Owns What—and When?

Phase	Community center lead	CAR-T center lead	Joint checkpoint
Referral / evaluation	Identify early; send complete packet; maintain routine care.	Assess candidacy; specify workup and interim restrictions.	Candidate decision and next milestone documented.
Pre-apheresis	Avoid unapproved therapy that may impair collection; monitor disease and infection.	Set collection timing, treatment holds, washouts, access and contingency plan.	Written “safe until apheresis” plan.
Manufacturing / bridging	Administer approved bridging/supportive care; report results/toxicities promptly.	Select/approve strategy; specify response assessment, washout, and stop criteria.	Weekly or risk-based review; no silent changes.
Lymphodepletion / infusion	Send updated treatment, toxicity, infection, transfusion, and medication record.	Final readiness; lymphodepletion, infusion, acute monitoring and toxicity management.	Handoff complete before lymphodepletion.
Acute postinfusion	Support only as directed; route urgent symptoms to CAR-T team.	Own product-required monitoring, CRS/ICANS response, admission/transfer plan.	Daily/high-risk communication as locally defined.
Transition back	Accept handoff; schedule labs/visits; follow thresholds and escalation plan.	Provide status, response, toxicities, medications, prophylaxis, thresholds and next visits.	Formal transition call/document.
Long-term	Monitor recovery, late effects, infection, cytopenias, relapse and survivorship.	Retain cellular-therapy oversight, response schedule, long-term reporting and consultation.	Shared surveillance and annual plan reconciliation.

Milestone update template

Field	Entry
Patient / diagnosis / product	
Current phase and milestone date	
Disease status / new symptoms	
Current therapy and last dose	
Key labs / imaging / infection status	
New toxicity, ED visit, admission, transfusion	
Decision needed—by whom and by when	
Next action / owner / due date / confirmation route	

4. Bridging Therapy: A Joint Treatment Plan

Bridging therapy is anticancer treatment given during the manufacturing interval. It can prevent loss of disease control and preserve the ability to reach infusion. In a retrospective LBCL cohort, response to bridging was associated with a 42% lower risk of progression or death after CAR-T; the authors emphasized intentional disease debulking and acknowledged selection bias and nonrandomized comparisons.⁵ In a small retrospective myeloma cohort, bispecific-antibody bridging produced high response rates, but sequencing remains an evolving, disease- and product-specific decision.⁶

THE GOAL

Control disease enough to reach CAR-T in the best achievable condition—without creating cytopenias, infection, organ toxicity, prolonged washout, or T-cell/target effects that jeopardize collection or infusion.

The plan must answer seven questions

- What is the purpose: stabilize, debulk, relieve symptoms, protect an organ, or all four?
- Should therapy begin only after leukapheresis? If pre-apheresis treatment is unavoidable, what is the collection risk?
- Which modality best fits disease biology, prior response, tempo, burden, organ function, and expected manufacturing time?
- What toxicities could delay lymphodepletion or make outpatient management unsafe?
- What labs, visits, imaging, and response criteria will be used—and who reviews them?
- What is the last allowable dose and required recovery/washout before lymphodepletion?
- What is Plan B for nonresponse, progression, manufacturing delay, or product failure?

Bridging options are not interchangeable

Option category	Potential role	Coordination risks to address
Systemic therapy	Disease-wide control; regimen chosen by disease, prior therapy and fitness.	Myelosuppression, infection, organ toxicity, recovery time, interactions, target/T-cell effects.
Radiation therapy	Focal control, symptom relief, or debulking in selected disease.	Field/dose, marrow exposure, timing, concurrent therapy, toxicity and response assessment.
Corticosteroids / symptom-directed care	Short-term control or palliation in selected situations.	Potential effects on disease assessment/immune therapy; dose, indication and stop date.
Targeted / immune therapy	May offer rapid or disease-specific control in selected settings.	Sequencing, antigen effects, immune fitness, washout, infection and evidence uncertainty.

Do not turn a study signal into a universal regimen. The treating CAR-T center should approve the modality, timing, and washout for the individual disease, product, and protocol.

5. Bridging Therapy Paired Checklist

Community	Action	CAR-T center	Action
☐	Send current disease burden, tempo, symptoms and recent response	☐	Define bridging goal and target response
☐	Confirm all prior agents, last doses and cumulative toxicities	☐	Confirm apheresis timing and precollection restrictions
☐	Assess CBC, renal/hepatic function, infection and performance status	☐	Approve regimen/modality, dose, schedule and site
☐	Confirm drug/radiation availability and payer authorization	☐	Provide washout/recovery requirements before lymphodepletion
☐	Document prophylaxis, transfusion/growth-factor and fever plan	☐	Specify supportive-care thresholds and prohibited agents
☐	Schedule labs/visits; provide named after-hours contact	☐	Specify response assessment and data-review dates
☐	Report each dose, hold, reduction, toxicity, infection, ED visit/admission	☐	Acknowledge reports and return decisions
☐	Do not add, stop or substitute treatment outside the agreed pathway	☐	Give explicit approval/revision with effective date
☐	Escalate progression or clinical decline the same day	☐	Activate alternate bridging, admission, or CAR-T timing decision
☐	Send final treatment/toxicity/lab record before lymphodepletion	☐	Confirm receipt and final readiness decision

Joint bridging order and monitoring record

Field	Jointly approved entry
Goal / target disease sites	
Regimen or radiation plan / rationale	
Apheresis date and pre-apheresis restrictions	
Start date / planned doses / administration site	
Lab and visit schedule / result recipient	
Supportive care / prophylaxis / transfusion thresholds	
Response assessment / date / reviewer	
Last allowable dose / washout / recovery criteria	
Hold / stop / urgent escalation criteria	
Plan B / manufacturing-delay plan	
Approving clinicians / date / version	

6. Before Lymphodepletion: Final Handoff

Community center confirms	Done	CAR-T center confirms	Done
All bridging doses, holds and last-dose date sent	☐	Treatment record received and reconciled	☐
Current disease status, symptoms and performance status sent	☐	Eligibility and disease plan reviewed	☐
Latest CBC/CMP and requested tests sent	☐	Recovery/washout criteria met	☐
Infections, cultures, antimicrobials and exposures sent	☐	Infection plan and proceed/hold decision documented	☐
ED visits, admissions, transfusions and toxicities sent	☐	Toxicities resolved/acceptable or mitigation documented	☐
Medication/allergy list reconciled	☐	Prophylaxis, holds and interactions reconciled	☐
Caregiver, travel and access changes reported	☐	Monitoring setting and logistics finalized	☐
Community contact for future transition verified	☐	Expected transition timing and handoff route stated	☐

STOP POINT

Lymphodepletion should not proceed on assumptions. The CAR-T center documents the final proceed/hold decision after receiving the updated clinical and treatment record.

Acute-period communication rule

During the center-defined acute monitoring window, new fever, neurologic change, hypotension, hypoxia, infection concern, or rapid deterioration is routed immediately to the CAR-T team and emergency pathway. The community site should not independently manage suspected CRS or ICANS unless a pre-authorized shared protocol explicitly assigns that role.

7. Return-to-Community Handoff

TRANSITION IS A CLINICAL EVENT

“Discharged” is not the same as “returned to routine oncology.” Transfer only when the CAR-T center defines the patient as ready and the receiving team confirms capability, appointments, thresholds, and escalation routes.

CAR-T center sends

Required element	Included	Receiving site confirms
Product, target, infusion date, lymphodepletion and treatment timeline	☐	☐
Disease status, next imaging, bone marrow, or disease-specific assessment	☐	☐
CRS, ICANS and other toxicities: grade, dates, treatment and residual effects	☐	☐
Infections, cultures, antimicrobial courses and isolation precautions	☐	☐
Current medication list, prophylaxis, holds, interactions and stop/review dates	☐	☐
CBC/CMP and immune-recovery trends; transfusion/growth-factor thresholds	☐	☐
Hypogammaglobulinemia/IVIG plan and immunoglobulin monitoring	☐	☐
Central-line plan and blood-product requirements	☐	☐
Visit/lab schedule and who reviews each result	☐	☐
Driving, proximity, caregiver and other product/program restrictions still active	☐	☐
Vaccination/revaccination plan and live-vaccine restrictions	☐	☐
Urgent symptoms, first-call number, ED/transfer destination and backup route	☐	☐
Next CAR-T visit and long-term follow-up/reporting obligations	☐	☐

Receiving-site acceptance

Item	Entry
Community clinician accepting handoff / date	
First visit and first laboratory date	
Results routed to / same-day review backup	
Medication reconciliation completed by	
Open issues and named owner	
CAR-T center follow-up date	
24/7 escalation route tested/confirmed	

8. Post-CAR-T Monitoring: What Continues

After acute monitoring, shared follow-up must continue for delayed cytopenias, infection, immune dysfunction, neurologic symptoms, organ effects, disease response, and survivorship needs. Monitoring intensity and duration remain product-, disease-, patient-, and center-specific.¹⁻⁴

Domain	Community monitoring / action	CAR-T center oversight / escalation
Disease response	Perform ordered imaging, marrow or disease-specific tests; report new symptoms promptly.	Set response schedule; interpret equivocal results; direct relapse evaluation.
Blood counts	Trend cytopenias; assess bleeding/infection; follow transfusion and growth-factor plan.	Guide prolonged/recurrent cytopenia workup and cellular-therapy-specific management.
Infection	Assess fever/exposures; follow prophylaxis and diagnostic plan; avoid delays in urgent evaluation.	Define prophylaxis duration, immune-recovery criteria and complex infection consultation.
Humoral immunity	Trend immunoglobulins/B-cell recovery when ordered; administer IVIG per plan.	Set thresholds, interval and reassessment criteria.
Neurologic / functional	Ask about cognition, speech, tremor, weakness, gait, sleep, mood and ability to function.	Evaluate persistent/new neurologic syndromes and late toxicity concerns.
Organ / metabolic	Monitor renal, hepatic, cardiac/pulmonary and nutritional status as indicated.	Direct workup for suspected treatment-related organ effects.
Medications	Reconcile at every transition; verify prophylaxis stop dates and interactions.	Approve major immune-modifying changes during defined oversight period.
Vaccination	Execute written revaccination schedule; avoid live vaccines until specifically cleared.	Define immune-recovery prerequisites and schedule.
Survivorship	Address fatigue, cognition, distress, return to work, financial toxicity and caregiver needs.	Maintain long-term cellular-therapy follow-up and reporting responsibilities.

Example shared follow-up planner—replace with local schedule

Timepoint	Community tasks	CAR-T center tasks / visit	Results owner / escalation
First visit after transition			
Weekly / risk-based early follow-up			
Day ~60			
Day ~90–100			
Month 6			
Month 12			
Annual / long-term			

9. Urgent Escalation and Communication Fail-Safes

CALL NOW

Fever; new confusion, speech/writing difficulty, tremor, weakness, seizure or altered alertness; hypotension, hypoxia, dyspnea or syncope; severe infection concern; rapid disease progression; major bleeding; or any abrupt clinical decline.

Situation	Community action	CAR-T center action
Immediately life-threatening	Activate emergency response/911; send CAR-T wallet information; call CAR-T center concurrently.	Alert ED/transfer pathway; provide product/date/toxicity guidance and accept/coordinate transfer.
Urgent but stable	Live call to 24/7 route; do not rely on portal/fax; obtain requested vitals/labs without delaying disposition.	Return disposition and treatment instructions; document receiving clinician and destination.
Expected result outside threshold	Call same day using designated results route; verify receipt.	Acknowledge, advise action, and set repeat/review time.
Cannot reach primary contact	Use backup number, transfer center, ED or emergency route in compact.	Maintain tested redundancy and update directory promptly.
Disagreement / ambiguity	Pause nonemergent plan changes; escalate clinician-to-clinician.	Name final decision owner; issue time-stamped revised plan.

Urgent call script

SAY THIS FIRST

“This patient received CAR-T: [product], infused [date]. Current location: [site]. New problem: [symptom/onset]. Vitals and neurologic status: [data]. Recent CAR-T toxicities/treatments: [summary]. I need a disposition decision now. Call-back number: [number].”

Communication audit fields

Date/time	Sender / receiver	Issue and urgency	Decision / owner / deadline	Read-back / closed loop confirmation

10. Shared Quality and Safety Dashboard

Measure	Definition	Review cadence	Owner / target
Referral completeness	Percent of referrals with required packet at first review.	Monthly	
Referral-to-consult time	Calendar days from referral receipt to CAR-T consult.	Monthly	
Consult-to-apheresis time	Calendar days; stratify by avoidable delay reason.	Monthly	
Bridging plan closure	Percent with signed regimen, monitoring, washout and Plan B before first dose.	Each case	
Bridging effectiveness	Response/stability/progression and proportion reaching infusion.	Quarterly	
Bridging harm/delay	Admissions, infections, cytopenias, organ toxicity or delayed lymphodepletion.	Quarterly	
Handoff reliability	Percent of milestone and transition handoffs complete/on time.	Monthly	
Urgent response time	Time from live escalation to disposition decision.	Each event	
Bed request-to-bed availability/admission	Minutes from formal bed request to bed availability and to patient admission; track both intervals.	Each event	
Tocilizumab order-to-administration	Minutes from tocilizumab order entry to start of administration.	Each event	
High-grade CRS onset-to-ICU transfer	Minutes from documented onset of Grade 3 or 4 CRS to ICU transfer/arrival.	Each event	
Unplanned ED/admission	Reason, site, transfer delay and preventability review.	Monthly	
Follow-up reliability	Missed labs/visits, unreviewed results and loss to follow-up.	Monthly	
Equity/access	Timeliness and completion by distance, payer, language and demographic groups.	Quarterly	

Case-review prompts

- Was referral early enough to preserve options?
- Did the patient ever have two conflicting plans?
- Was bridging response measured and toxicity anticipated?
- Did every transition have an accepting clinician and scheduled next step?
- Were urgent routes used, answered, and documented?
- What system change—not individual reminder—will prevent recurrence?

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