

APP MENTORSHIP PROGRAM BISPECIFIC ANTIBODY TOXICITY MANAGEMENT & PATIENT EDUCATION WEEK 5 CURRICULUM



Improving Lives **Finding the Cure®**

Learning Objectives

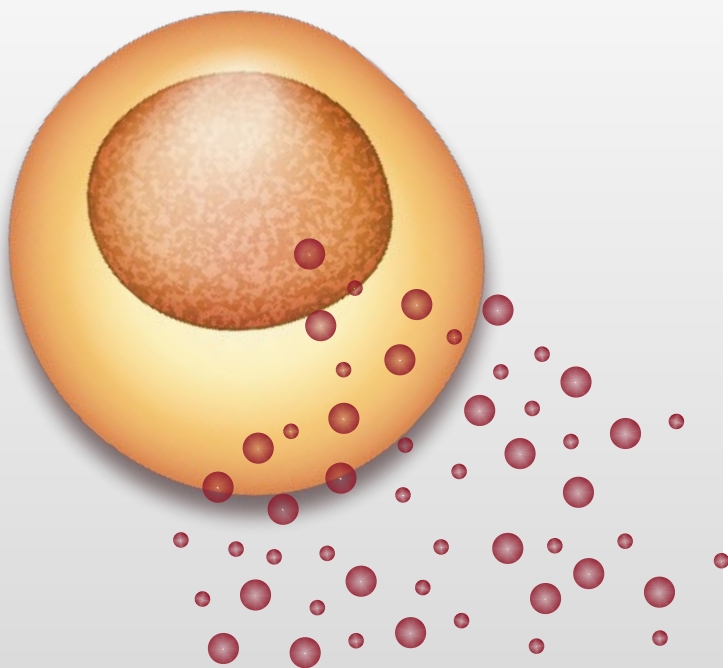
Review the incidence of common adverse events with bispecific antibodies

Describe best practices in the management of CRS, infections, and other toxicities associated with bispecifics antibodies

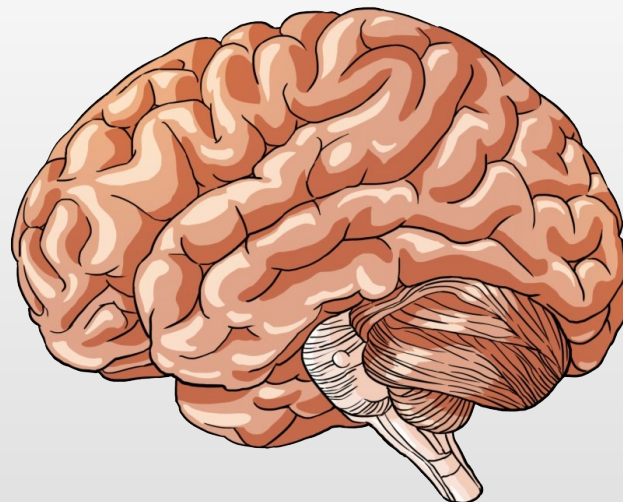
Outline strategies for patient education, monitoring, and interdisciplinary care.

Bispecific Antibodies: Key Side Effects

Cytokine release syndrome (CRS)

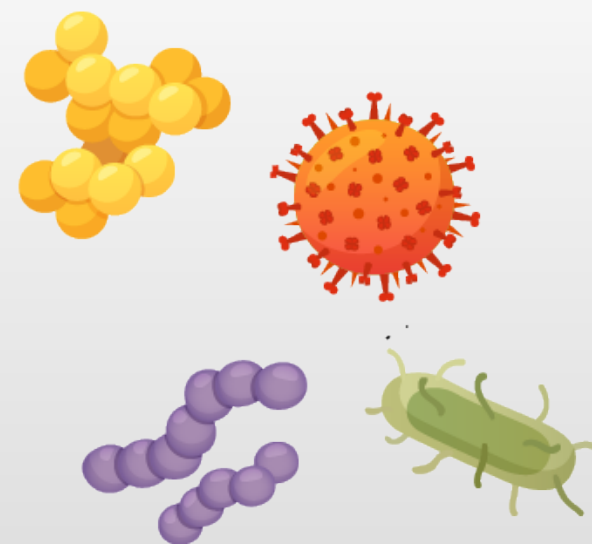


Immune effector cell-associated neurotoxicity syndrome (ICANS)



Neurotoxicity

Infection



CRS & ICANS: what's different from CAR-T

Lower grade, mostly fever

CRS is common (~40–70%) but almost entirely grade 1 — fever ± mild hypotension. Grade ≥ 3 is rare. ICANS is uncommon and usually low-grade.

Spread across the ramp week

Unlike CAR-T's early spike, events track the step-up doses. Time-to-CRS in HCl data $\approx$ 2.5–3.5 days. Monitor through each step, not just day 1.

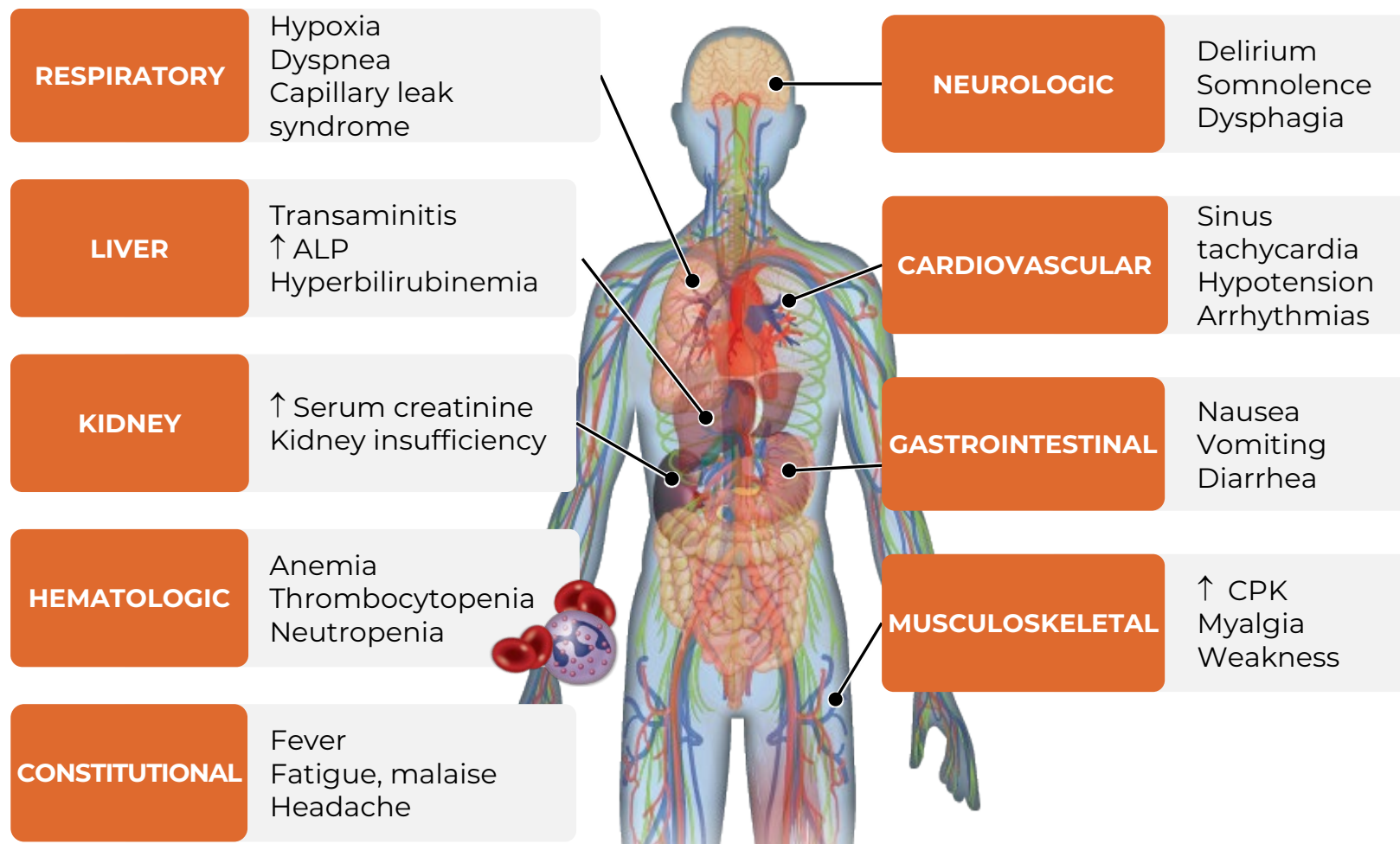
Same toolkit you already have

Tocilizumab 8 mg/kg IV ($\pm$ repeat) $\pm$ dexamethasone; acetaminophen, IV fluids; rule out infection every time. A pre-signed order set + trained RNs = safe response.

Don't forget the mimics

Hypercalcemia, infection, and metabolic derangements imitate ICANS — work them up before escalating immunosuppression (as in LW's case).

CRS: Early Recognition and Treatment Is Key



Monitoring for CRS

- **Vital signs (temperature, O₂ saturation, etc)**
- Review of systems and physical exam
 - Focus on cardiovascular, pulmonary, and neurologic systems
- Rule out infection
- Laboratory monitoring
 - CRP
 - Cytokines
 - Ferritin
 - LDH

ALP = alkaline phosphatase; CPK = creatine phosphokinase; CRP = C-reactive protein; CRS = cytokine release syndrome; LDH = lactate dehydrogenase; O₂ = oxygen.

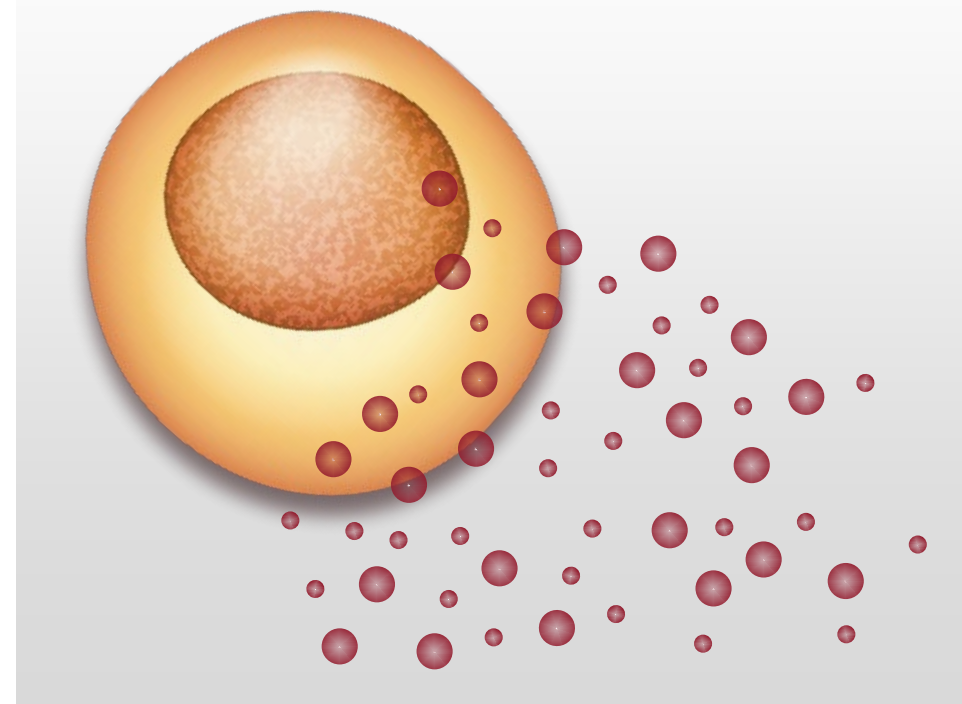
Oluwole OO, Davila ML. *J Leukoc Biol.* 2016;100:1265-1272. June CH, et al. *Science.* 2018;359:1361-1365. Brudno JN, Kochenderfer JN. *Blood.* 2016;127(26):3321-3330. Brudno JN, Kochenderfer JN. *Blood Rev.* 2019;34:45-55. Shimabukuro-Vornhagen, et al. *J Immunother Cancer.* 2018;6:56. Lee DW, et al. *Biol Blood Marrow Transplant.* 2019;25:625-638.

IMWG Immunotherapy Committee: CRS

Important Points for Bispecific Antibodies in MM

- **CRS is a systemic inflammatory reaction** caused by T-cell activation and the release of proinflammatory cytokines
- Bispecific antibodies for multiple myeloma induce **CRS, which is mostly grade 1 or 2**
 - Generally less severe than CRS with CAR T
- The **frequency of CRS varies for different bispecific antibodies** due to various factors
- Diagnostic investigation of CRS involves a detailed medical history, physical examination, and laboratory investigations
- **Consideration for the prophylactic use of tocilizumab** has been added to the NCCN guidelines
- The **grading and management of CRS** involve different strategies based on the severity of the syndrome

Cytokine release syndrome (CRS)



CAR = chimeric antigen receptor; CRS = cytokine release syndrome; IMWG = International Myeloma Working Group; MM = multiple myeloma.
Rodriguez-Otero P, et al. *Lancet Oncol.* 2024;25:e205-216. National Comprehensive Cancer Network® (NCCN®) NCCN Clinical Practice Guidelines In Oncology (NCCN Guidelines®) for Multiple Myeloma. Version 5.2026. To view the most recent or complete version of the guideline, go online to [NCCN.org](https://www.nccn.org).

When to Expect CRS: Incidence, Timing, and Severity

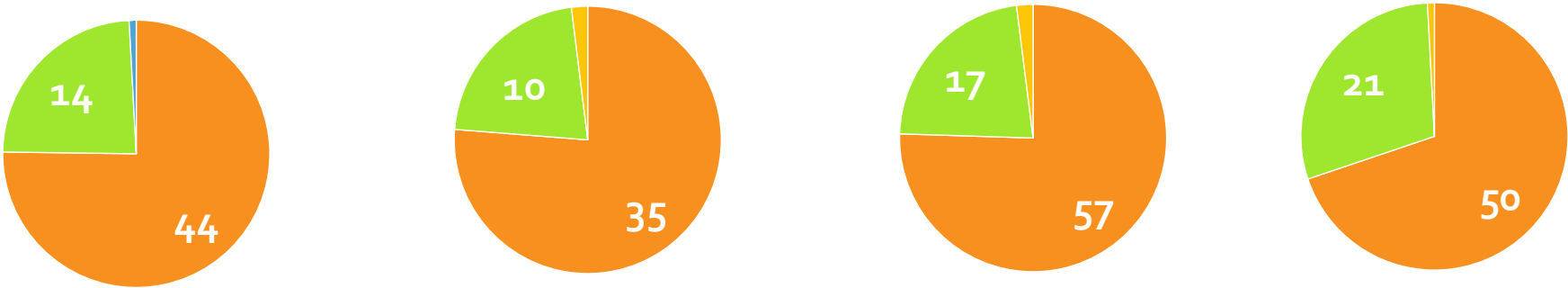
CRS	Elranatamab	Linvoseltamab	Talquetamab*	Teclistamab
Any grade, %	58	46	76	72
Median time to onset, days (Range) [†]	2 (1-9)	0.46 (-0.05 to 7.65)	2 (1-8)	2 (1-6)
Median duration, days (Range) [†]	2 (1-19)	0.65 (0.04 to 4.00)	2 (1-13)	2 (1-9)

[†]Broken down by dose. Median is after each dose not as aggregate.

*Talquetamab dose 0.4 mg/kg weekly.

CRS by Grade, %

- Grade 1
- Grade 2
- Grade ≥3



ASTCT CRS Consensus Grading

CRS Parameter	Grade 1	Grade 2	Grade 3	Grade 4
Fever^a	Temperature $\geq 38^{\circ}\text{C}$	Temperature $\geq 38^{\circ}\text{C}$	Temperature $\geq 38^{\circ}\text{C}$	Temperature $\geq 38^{\circ}\text{C}$
		WITH		
Hypotension	None	Not requiring vasopressors	Requiring a vasopressor with or without vasopressin	Requiring multiple vasopressors (excluding vasopressin)
		AND/OR ^b		
Hypoxia	None	Requiring low-flow nasal cannula ^c or blow-by	Requiring high-flow nasal cannula, ^c face mask, nonrebreather mask, or Venturi mask	Requiring positive pressure (eg, CPAP, BiPAP, intubation and mechanical ventilation)

Organ toxicities associated with CRS may be graded according to Common Terminology Criteria for Adverse Events v5.0 but not influence CRS grading.

^aFever is defined as temperature $\geq 38^{\circ}\text{C}$ not attributable to any other cause. In patients who have CRS and receive antipyretic or anticytokine therapy such as tocilizumab or steroids, fever is no longer required to grade subsequent CRS severity. In this case, CRS grading is driven by hypotension and/or hypoxia. ^bCRS grade is determined by the more-severe event: hypotension or hypoxia not attributable to any other cause. For example, a patient with a temperature of 39.5°C , hypotension requiring 1 vasopressor, and hypoxia requiring low-flow nasal cannula is classified as grade 3 CRS. ^cLow-flow nasal cannula is defined as oxygen delivered at $\leq 6\text{ L/minute}$. Low flow also includes blow-by oxygen delivery, sometimes used in pediatrics.

High-flow nasal cannula is defined as oxygen delivered at $> 6\text{ L/minute}$.
 ASTCT = American Society for Transplantation and Cellular Therapy; BiPAP = bilevel positive airway pressure; CPAP = continuous positive airway pressure; CRS = cytokine release syndrome.
 Lee DW, et al. *Biol Blood Marrow Transplant*. 2019;25:625-638.

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Managing CRS Is Institution Specific – these are

ASTCT CRS Grade	Management (Example Guideline)
1	- Antipyretics and IV hydration - Diagnostic workup to rule out infection - Antibiotics if neutropenic - Consider tocilizumab +/- step-up dosing
2	- Supportive care as in grade 1 - IV fluid boluses and/or supplemental oxygen Tocilizumab ± dexamethasone (or its equivalent of methylprednisolone)
3	- Supportive care as in grade 1 - Consider monitoring in ICU - Vasopressor support and/or supplemental oxygen Tocilizumab + dexamethasone 10 to 20 mg IV every 6 hours (or its equivalent of methylprednisolone)
4	- Supportive care as in grade 1 - Monitoring in ICU - Vasopressor support and/or supplemental oxygen via positive-pressure ventilation Tocilizumab + methylprednisolone 1000 mg/day

Toci and dexamethasone are usually sufficient to treat g1 CRS

ASTCT = American Society for Transplantation and Cellular Therapy; CRS = cytokine release syndrome; ICU = intensive care unit; IV = intravenous.
 Neelapu SS, et al. *Nat Rev Clin Oncol*. 2018;15:47-62. Neelapu SS, et al. *Hematol Oncol*. 2019;37(suppl 1):48-52.

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Neurotoxicity: Rare but Potentially Serious AE



Monitoring for ICANS

- ICE screening tool
- Review of systems and physical exam
 - Focus on neurologic system
- Rule out infection
- If ICANS suspected
 - Neuroimaging (ideally MRI)
 - Diagnostic lumbar puncture for opening pressure and infection tests
- Corticosteroids are typically indicated for ICANS $\geq$ grade 2
- Patient and care partner information

AE = adverse event; ICANS = immune effector cell-associated neurotoxicity syndrome; ICE = immune effector cell encephalopathy; MRI = magnetic resonance imaging.
 Brudno JN, Kochenderfer JN. *Blood*. 2016;127(26):3321-3330. Lee DW, et al. *Biol Blood Marrow Transplant*. 2019;25:625-638.

Screening Tool for Neurologic Assessment

Assessment		Points
Orientation	Orientation to year, month, city, hospital	4
Naming	Ability to name 3 objects (eg, point to clock, pen, button)	3
Following Commands	Ability to follow simple commands (eg, "Show me 2 fingers" or "Close your eyes and stick out your tongue")	1
Writing	Ability to write a standard sentence (eg, "Our national bird is the bald eagle")	1
Attention	Ability to count backwards from 100 by 10	1
Total Points		10

Scoring	
10	No impairment
7-9	Grade 1 ICANS
3-6	Grade 2 ICANS
0-2	Grade 3 ICANS
0 due to patient unarousable and unable to perform ICE assessment	Grade 4 ICANS

ICANS = immune effector cell-associated neurotoxicity syndrome; ICE = immune effector cell encephalopathy.
 Santomasso B, et al. *Am Soc Clin Oncol Educ Book*. 2019;39:433-444. Lee DW, et al. *Biol Blood Marrow Transplant*. 2018;15:47-62.

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Neurotoxicity unlikely with Bispecific Antibodies

- Can occur:
 - In the absence of CRS
 - Concurrent with CRS
 - More commonly, after CRS
- Considered to be a distinct process from CRS
- The exact mechanism of neurologic toxicity is not known
- Endothelial injury, possibly resulting from proinflammatory cytokines, may contribute
- Onset can vary widely and can be acute or chronic
 - Short-term acute (eg, palsy) vs delayed onset (eg, lack of focus, or “chemo brain”)
- Toxicities tend to be self-limited and reversible

3/27	I LOVE MY FAMILY!
3/28	I LOVE MY FAMILY!
3/28	I LOVE MY FAMILY!
3/29	~~I LOVE MY FAMILY!~~
3/29	~~I LOVE MY FAMILY!~~

CRS = cytokine release syndrome.

Lee DW, et al. *Biol Blood Marrow Transplant*. 2019;25:625-638. Brudno JN, Kochenderfer JN. *Blood*. 2016;127(26):3321-3330. Oluwole OO, Davila ML. *J Leukoc Biol*. 2016;100:1265-1272. June CH, et al. *Science*. 2018;359:1361-1365. Brudno JN, Kochenderfer JN. *Blood Rev*. 2019;34:45-55. Catamero D, et al. Presented at: 20th International Myeloma Society (IMS) Annual Meeting Nurse Symposium; September 27-30, 2023; Athens, Greece.

When to Expect Bispecific Antibody Associated Neurologic Toxicity

Patients, %	Any Grade Neurotoxicity	Grade ≥3 Neurotoxicity	Any Grade ICANS
Elranatamab	59	7	3.3
Linvoseltamab	54	8	8
Talquetamab	55	6	9
Teclistamab	57	2.4	6

- 3 main types: headache, peripheral neuropathy, ICANS
 - Much less common with BsAb compared with CAR T-cell therapy
 - Neurologic exam with ICE grade score and dexamethasone as directed

Incidence of Bispecific Antibody Associated Infection

Target	Agents	Trial	Any Grade Infections, %	Grade ≥3 Infections, %
BCMA-directed	Elranatamab	MagnetisMM-3	70	40
	Linvoseltamab	LINKER-MM1	74	36
	Teclistamab	MajesTEC-1	76	45
GPRC5D-directed	Talquetamab	MonumenTAL-1	59*	20*

*Talquetamab dose 0.4 mg/kg weekly.

Patients remain susceptible to infections throughout the duration of bispecific antibody therapy, particularly those receiving BCMA-directed agents

Moreau. N Engl J Med. 2022;387:495. Teclistamab PI. Lesokhin. Nat Med. 2023;29:2259. Elranatamab PI. Chari. N Engl J Med. 2022;387:2232. Talquetamab PI. Bumma. J Clin Oncol. 2024;42:2702. Linvoseltamab PI. Bangolo. Cancers (Basel). 2025;17:282.

Medications to Reduce Infection Risk

Type of Infection Risk	Medication Recommendation(s)
Viral: herpes simplex (HSV/VZV); CMV	Acyclovir prophylaxis
Viral: influenza, COVID-19	Consider antiviral therapy if exposed or positive for influenza or COVID-19 , per institution recommendations
Hepatitis B virus (HBV) reactivation	Entecavir prophylaxis in patients positive for chronic HBV infection (defined as serologically positive for hepatitis B surface antigen [HBsAg]) if treated with CAR T-cell therapy, bispecific antibodies, or daratumumab
Bacterial: blood, pneumonia, and urinary tract infection	Consider prophylaxis with quinolone for ANC < 500 cells/μL
Pneumococcal infection	The Centers for Disease Control and Prevention recommends pneumococcal vaccination (1 dose of PCV20 or 1 dose of PCV 15 followed by 1 dose of PPSV23 at least 1 year later); CAR T-cell therapy or ASCT: revaccinate 3 to 6 months after treatment; bispecific: update vaccination status prior to starting therapy
<i>Pneumocystis jirovecii</i> pneumonia (PJP)	Consider prophylaxis with trimethoprim-sulfamethoxazole or pentamidine
IgG < 400 mg/dL ^a (general infection risk)	IVIG replacement (400 mg/kg once every 4 weeks) is indicated; IVIG replacement during CAR T-cell and bispecific antibody therapy is not guided by the presence of infections^a CAR T-cell therapy: day +30 through 1 year. After 1 year continue until serum IgG > 400 mg/dL Bispecific: start at the second cycle of therapy and continue until the end of therapy or serum IgG > 400 mg/dL
Absolute neutrophil count (ANC) < 1000 cells/μL (general infection risk)	Consider GCSF 2 or 3 times/week (or as frequently as needed) to maintain ANC > 1000 cells/μL and treatment dose intensity; CAR-T cell therapy: start oral levofloxacin at 500 mg daily ^b or per clinician discretion and continue through neutrophil recovery; bispecific: consider starting with therapy and administer throughout the first cycle

^aIVIG is indicated in all patients with MM receiving CAR T or BCMA bispecific therapy. ^bAlternatives: cefdinir 300 mg by mouth twice a day or amoxicillin/clavulanate 875 mg by mouth twice a day. ASCT = autologous stem cell transplant; BCMA = B-cell maturation antigen; CAR = chimeric antigen receptor; CMV = cytomegalovirus; GCSF = granulocyte colony-stimulating factor; HSV = herpes simplex virus; IgG = immunoglobulin G; IVIG = intravenous immunoglobulin; MM = multiple myeloma; PCV = pneumococcal conjugate vaccine; PPSV = pneumococcal polysaccharide vaccine; VZV = varicella zoster virus.
Raje NS, et al. *Lancet Haematol.* 2022;9(2):143-161. National Comprehensive Cancer Network® (NCCN®) NCCN Clinical Practice Guidelines In Oncology (NCCN Guidelines®) for Multiple Myeloma. Version 5.2026. To view the most recent or complete version of the guideline, go online to NCCN.org. Cao W, et al. *Blood.* 2020;136(4):516-519.
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Bispecific Antibody Clinical Pearls

- **Step-up dosing essential; dosing schedule are specific to each bispecific antibody**
 - CRS and neurotoxicity more likely during step-up and early doses; unlikely later
 - May need to repeat step-up dosing after a dose delay
- **First dose on Monday, Tuesday if able so CRS or other AEs during the week**
- **Consider care partner needs (formal or informal)**
- **REMS program for each bispecific antibody:**
 - Prescribers and institutions must be certified
 - Nurses must be trained on AE monitoring requirements
 - Start REMS training early
- **Premedication**
 - Corticosteroid (oral or intravenous dexamethasone, 16 mg or equivalent)
 - Antihistamines (oral or intravenous diphenhydramine, 50 mg or equivalent)
 - Antipyretics (oral or intravenous acetaminophen, 650 mg to 1000 mg or equivalent)
- **AEs specific to target (BCMA vs GCR5D); individualize support**
- **Consider inpatient vs outpatient**

AE = adverse event; BCMA = B-cell maturation antigen; CRS = cytokine release syndrome; GPCR5D = G-protein coupled receptor family C group 5 member D; GPCR5D = G-protein coupled receptor family C group 5 member D; REMS = Risk Evaluation and Mitigation Strategies. IMF Nurse Leadership Board experience. TECVAYLI® (teclistamab-cqyv) Prescribing Information. ELREXFIO® (elranatamab-bcmm) Prescribing Information. LYNZOZYFIC™ (linvoseltamab-gcpt) Prescribing Information. TALVEY® (talquetamab-tgvs) Prescribing Information.

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Before, During, and Throughout Bispecific Therapy

BEFORE

- Plan for next therapy
 - Consider bispecific, CAR T-cell therapy, clinical trial, other options
- For bispecific
 - Referral (if needed)
 - Evaluation
- Transition of care needs
- Plan ramp-up dosing inpatient/outpatient
- REMS
- Prophylaxis for infection
- Wallet cards

DURING RAMP-UP

- Close monitoring for 48 hours post dose
 - CRS (watch for fever)
 - Neurotoxicity
 - Cytopenias
 - Infections
 - Liver function labs
 - HLH/MAS (rare but serious)
 - Fatigue
- Other labs per institution protocol

THROUGHOUT

- Microbial prophylaxis
- Continued monitoring for AEs (especially infection)
- Manage dosing schedule adjustments
- **Monthly IVIG**
- Immunizations
- Disease response and progression monitoring (monthly laboratory testing and imaging)

AE = adverse event; CAR = chimeric antigen receptor; CRS = cytokine release syndrome; HLH = hemophagocytic lymphohistiocytosis; IVIG = intravenous immunoglobulin; MAS = macrophage activation syndrome; REMS = Risk Evaluation and Mitigation Strategies.

Maus MV, et al. *J Immunother Cancer*. 2020;8(2):e001511. Cohen AD, et al. *Blood Cancer J*. 2022;12(2):32. Chakraborty R, et al. *Transplant Cell Ther*. 2021;27:222-229.

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Inpatient vs Outpatient Bispecific Administration

Why site of care matters: Patient experience, healthcare resource use, and access depend on where step-up dosing occurs

INPATIENT

- **SUD Monitoring**

- Average 7 days inpatient hospitalization for full SUD phase
- Continuous nursing monitoring provided by inpatient unit

- **Patient Experience**

- Extended time away from home
- ~ 30% of patients have no CRS during SUD; prophylactic admission may not be required

- **Financial/Access**

- Drug costs bundled into DRG; reimbursement may not cover full costs
- Limited inpatient beds creates access barriers at smaller centers

OUTPATIENT

- **SUD Monitoring**

- Outpatient clinic visit for each SUD administration; vitals monitored remotely at home by caregiver
- Feasible and safe with proper patient selection, caregiver support, and protocols

- **Patient Experience**

- Patients sleep at home between SUD visits
- Caregiver monitors vitals every 4 hours post dose
- Caregiver must recognize CRS/neurotoxicity symptoms and know when and who to call

- **Financial/Access**

- Drug billed separately via Medicare Part B (ASP + markup) through OPSS
- Outpatient SUD can reduce healthcare resource use and costs vs inpatient SUD
- > 80% of patients at some centers now initiated outpatient

ASP = average selling price; CRS = cytokine release syndrome; DRG = diagnosis-related group; OPSS = Outpatient Prospective Payment System; SUD = step-up dose.

Olivieri DJ, Banerjee R. *JCO Oncol Pract*. 2025;21(5):596-598. Mahmoudjafari Z, et al. *J Adv Pract Oncol*. 2024. doi:10.6004/jadpro.2024.15.8.15. Online ahead of print. van de Donk NWCJ, et al. *Blood*. 2025;146(Suppl 1):7936-7937.

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Management of Oral Toxicities With Talquetalmab

Dysgeusia (Taste Changes)

Dexamethasone oral solutions have been studied but with **no proven benefit and can actually make worse Sweet/salty declines first.**

Sour citrus or candies before meals are recommended.

TALISMAN study ongoing

Dry Mouth

OTC dry mouth rinse, gel, spray are recommended. Advise patients to avoid hot beverages.

Dysphagia (Difficulty Swallowing)

Dietary modifications, including taking small bites, eating upright, and taking sips of beverage with food, can help manage symptoms.



Clinical Pearl: If patients are not tolerating due to oral toxicities, use a low threshold for dose reduction or dosing interval change

Glossitis and Thrush

EARLY initiation of nystatin or clotrimazole is key to managing symptoms.

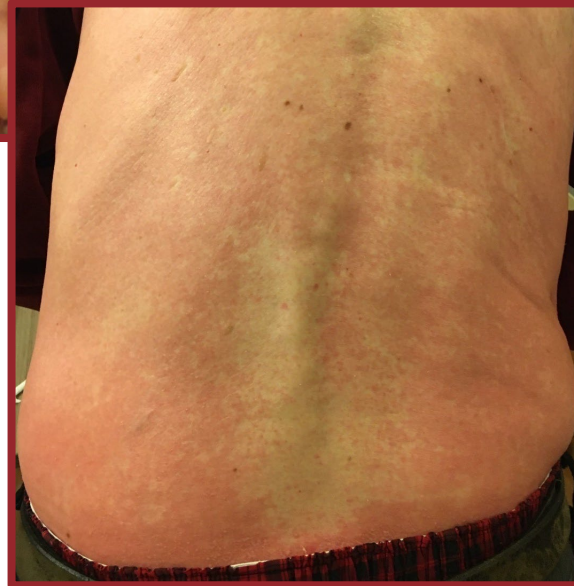
- **Weight loss and anorexia** are associated with taste changes. **Nutritionist** involvement and dietary modifications are recommended to support patients. An appetite stimulant with dronabinol, if indicated, can also be utilized
- **Education and emotional support are key strategies for managing oral toxicities**

OTC = over the counter.

Catamero D, et al. *Semin Oncol Nurs*. 2024;40(5):151712. Catamero D, et al. Presented at: 20th International Myeloma Society (IMS) Annual Meeting Nurse Symposium; September 27-30, 2023; Athens, Greece. Chari A, et al. ASH 2023. Abstr #1010.

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Examples of Skin/Nail AEs With Talquetamab



Photos: Mount Sinai Hospital, NY, NY.
AE = adverse event.

Unique Side Effects with Talquetamab:

Management of Dermatologic AEs



Clinical Pearl: Dermatologic AEs can be difficult to manage; dose adjustment may be needed

Dry Skin

Heavy moisturizers

Hand and/or Foot Peeling

Ammonium lactate 12% lotion to soles and palms twice daily

Nail Thinning and Peeling

Nail hardeners, topical vitamin E oil, and triamcinolone 0.025% ointment

Pruritus

Loratadine 10 mg by mouth daily for 3 to 5 days after talquetamab dose and triamcinolone 0.1% cream twice daily

Injection Site Reaction

Body Rash/Drug Rash

Above, plus consider methylprednisolone taper and betamethasone 0.05% cream twice daily

- Consider dose HOLD for other grade 3 dermatologic AEs
- Dermatology consults may be helpful as an early strategy
- **With experience, dermatologic AEs can be managed more easily than oral AEs**
- These interventions were successful at reducing or resolving dermatologic AEs

AE = adverse event.

Catamero D, et al. *Semin Oncol Nurs*. 2024;40(5):151712. Catamero D, et al. Presented at: 20th International Myeloma Society (IMS) Annual Meeting Nurse Symposium; September 27-30, 2023; Athens, Greece.

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Challenges for Bispecific Antibodies in the Community

- **Referral bias**
 - Appropriate timing
 - Need to be at a referral institution, at least for therapy initiation
- **Hospitalization requirements**
- **Logistics of traveling to a larger institution**
 - Unreimbursed costs for travel, food, and lodging
 - Need for a caregiver

Management of toxicities

- Community expertise
- Implementing REMS programs in the community setting

REMS requirements

- Each bispecific requires its own program
- Community may have REMS program only for certain bispecifics

Financial

- Insurance coverage

APs can assist with Care Transitions

See IMF's
Myeloma University
for a discussion
of care transitions



<https://university.myeloma.org>

TASK	RESPONSIBLE TEAM (PROVIDER)
Care coordination	Cellular therapy center and community oncology team (RN or APP)
Send referral to cellular therapy center	Community oncology team (RN or APP)
Send past treatment history and responses	Community oncology team (RN or APP)
Coordination of appointment	Cellular therapy center (RN) and community oncology team (RN)
REMS certification by community oncology team	Community oncology team (medical doctor and/or APP)
Patient education regarding treatment	Cellular therapy center (RN, APP, or medical doctor) and community oncology team (RN or APP)
Communicate status of financial clearance to patient and community oncology team	Cellular therapy center (RN)

APP = advanced practice provider; REMS = Risk Evaluation and Mitigation Strategy; RN = registered nurse.

Bellerive C, Steinbach M, Faiman B, Richards TA. *Clin J Oncol Nursing*. 2025;29(1):E7-E16..

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Evolution in Health Care: From Single Provider to Care by Multidisciplinary Team.

Provide patients with a contact list of your providers

- Name, address, scheduling number, emergency number (if needed)

Help patients understand their different roles

Underscore that patients are part of the team

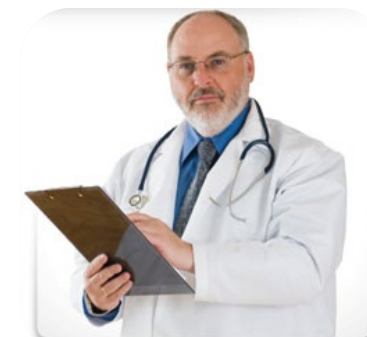
- Often treated as “outpatient”
- Patient and caregivers have many responsibilities! Can be overwhelming!
- Be empowered:
 - Ask questions
 - Participate in decisions
 - Communicate effectively with your entire team



Primary Care Provider (PCP)



Subspecialists



General Hem/Onc



Patient and Care Partner(s)



Specialist



Family/Support Network



Allied Health Staff

Best Practices: Shared Decision-Making with Bispecific Antibodies

- ▶ **Provide patients time to consider options (if needed/appropriate)**
- ▶ **Understand options; consider priorities**
 - Use reliable sources of information
 - Use caution considering stories of personal experiences
 - Consider goals/values/preferences
- ▶ **Encourage patients to express their goals/values/preferences; create a dialog**
 - Help patients to understand top priorities/goals/values; additional [preferences] are also important.
 - I think [treatment] may be a good choice given my priorities... What do you think?
- ▶ **Arrive at a treatment decision together**



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**Help patients
to Prepare for
In-Person
Visits:
Encourage
Patients/Care
Partners to**

Before the appointment:

Write down questions

Bring an updated medication list

Track symptoms and side effects

Bring a family member or friend if possible

Know your treatment history

During the visit:

Take notes

Ask for clarification

Review next steps before leaving

Additional Points Regarding Patient Education and Decision-Making

Additional Strategies:

- Bring a list of current medications, prescribed and over the counter
- Write down questions and concerns. Prioritize them including financial issues
- Have there been any medical or life changes since your last visit?
- Current symptoms - how have they changed (improved, worsened, stable)? Keep a symptom diary. Bring it along
- Communicate effectively: The health care team can't help if they don't know



Key Takeaways

- **Bispecific antibodies** act as a bridge between T cells and myeloma cells to use a patient's immune system to target myeloma. **Teclistamab, elranatamab, linvoseltamab, and talquetamab** are currently FDA approved; more are in development.
- **CRS, neurotoxicity, and hematologic toxicities** are important AEs for all **bispecific antibodies**.
- **BCMA-directed** bispecific antibodies carry heightened **infection risk; monthly and antibiotic, antiviral prophylaxis and IVIG during treatment is recommended**
- **GPRC5D-directed** bispecific antibodies carry the **possibility of skin, nail, and oral AEs**.
- Best practices for transitions of care include **using a structured handoff process** that may include verbal communication, written instructions, and patient/caregiver involvement.

OUR MISSION:

Improving the quality of life of myeloma patients while working toward prevention and a cure.

OUR VISION:

A world where every myeloma patient can live life to the fullest, unburdened by the disease.