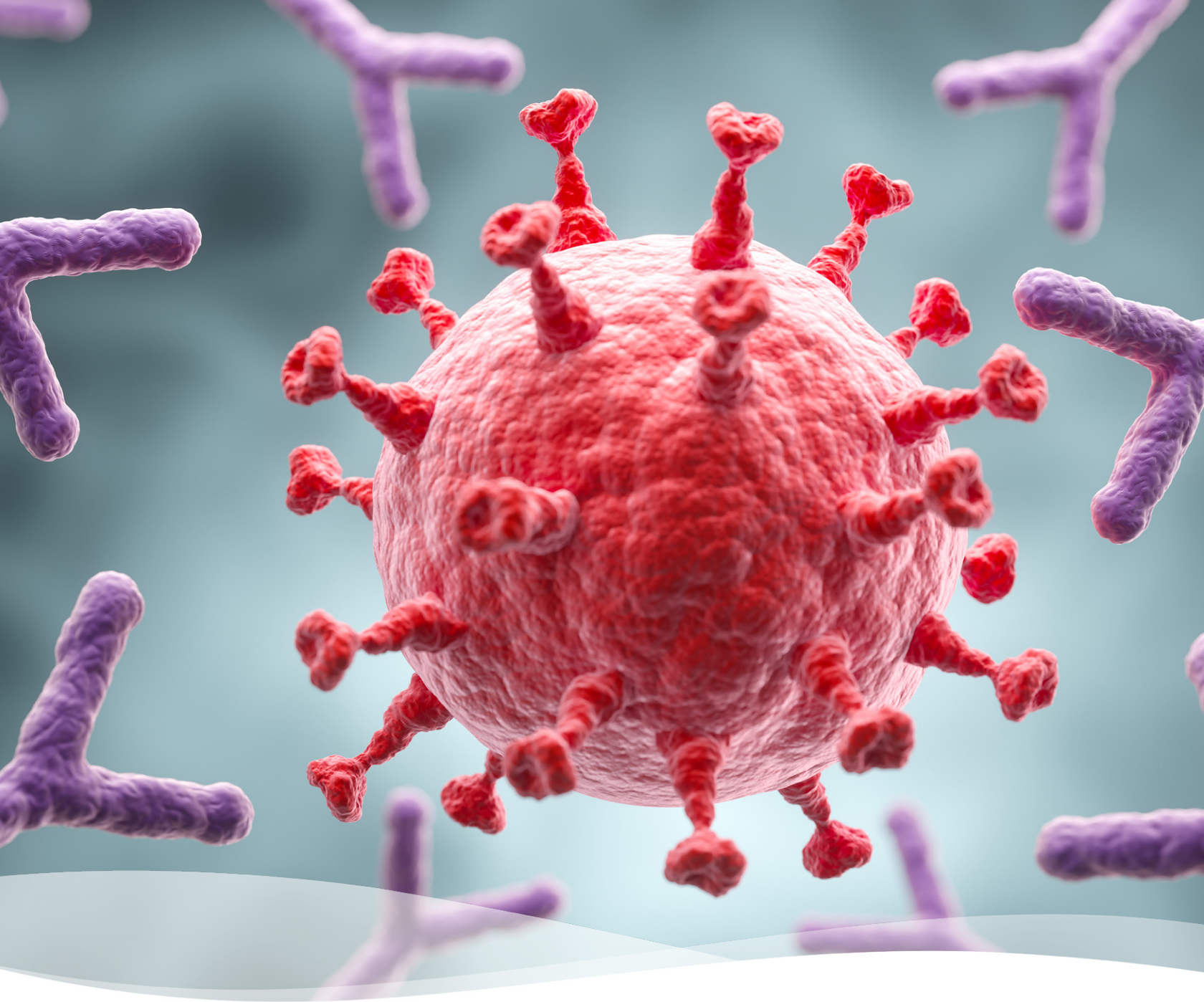
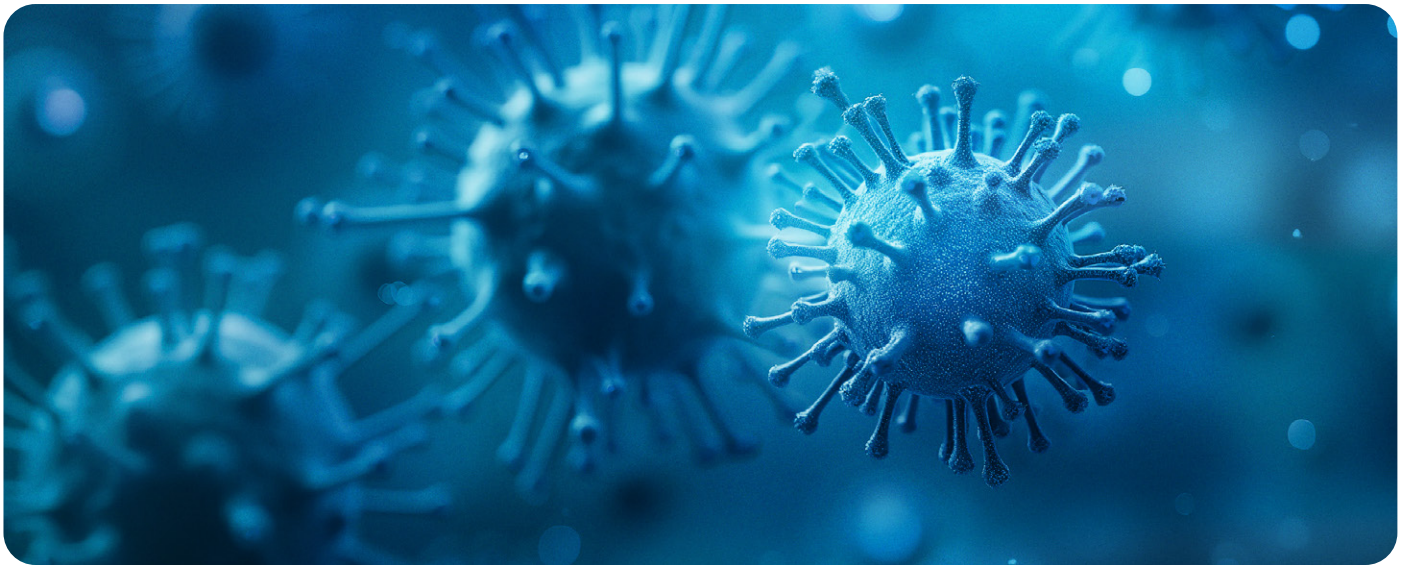


Best Practices in CAR-T Care:
Patient Identification, Referral, and Long-Term Management

Discussion with the International Myeloma Foundation Nurse Leadership Board

INTERNATIONAL MYELOMA FOUNDATION

NURSE LEADERSHIP BOARD



OVERVIEW

The emergence of chimeric antigen receptor T-cell (CAR-T) therapy has reshaped the treatment landscape for multiple myeloma, introducing a cellular therapy capable of producing deep and durable responses after a single treatment course. B-cell maturation antigen (BCMA)-directed CAR-T therapies initially demonstrated substantial activity in heavily pretreated relapsed and refractory multiple myeloma, and subsequent randomized studies established their clinical benefit earlier in the treatment course.[1, 2, 3, 4]

In the United States, two BCMA-directed CAR-T products are currently approved for multiple myeloma: ABECMA® (idecabtagene vicleucel; ide-cel) and CARVYKTI® (ciltacabtagene autoleucel; cilta-cel). Both therapies have demonstrated deep and durable responses in patients with relapsed or refractory multiple myeloma, and phase 3 studies have established the benefit of CAR-T therapy in earlier lines of treatment.[5, 6] ABECMA is currently indicated for adults with relapsed or refractory multiple myeloma after two or more prior lines of therapy, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody, while CARVYKTI is indicated for adults with relapsed or refractory multiple myeloma after at least one prior line of therapy that included a proteasome inhibitor and an immunomodulatory agent and whose disease is refractory to lenalidomide.[7, 8]

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[1] Munshi NC, Anderson LD Jr, Shah N, Madduri D, Berdeja J, Lonial S, et al. Idecabtagene vicleucel in relapsed and refractory multiple myeloma. N Engl J Med. 2021;384(8):705-716. doi:10.1056/NEJMoa2024850.

[2] Berdeja JG, Madduri D, Usmani SZ, Jakubowiak A, Agha M, Cohen AD, et al. Ciltacabtagene autoleucel, a B-cell maturation antigen-directed chimeric antigen receptor T-cell therapy in patients with relapsed or refractory multiple myeloma (CARTITUDE-1): a phase 1b/2 open-label study. Lancet. 2021;398(10297):314-324. doi:10.1016/S0140-6736(21)00933-8.

[3] Rodriguez-Otero P, Ailawadhi S, Arnulf B, Patel K, Cavo M, Nooka AK, et al. Ide-cel or standard regimens in relapsed and refractory multiple myeloma. N Engl J Med. 2023;388(11):1002-1014. doi:10.1056/NEJMoa2213614.

[4] San-Miguel J, Dhakal B, Yong K, Spencer A, Anguille S, Mateos MV, et al. Ciltacabtagene autoleucel or standard care in lenalidomide-refractory multiple myeloma. N Engl J Med. 2023;389(4):335-347. doi:10.1056/NEJMoa2303379.

[5] Rodriguez-Otero P, Ailawadhi S, Arnulf B, Patel K, Cavo M, Nooka AK, et al. Ide-cel or standard regimens in relapsed and refractory multiple myeloma. N Engl J Med. 2023;388(11):1002-1014. doi:10.1056/NEJMoa2213614.

[6] San-Miguel J, Dhakal B, Yong K, Spencer A, Anguille S, Mateos MV, et al. Ciltacabtagene autoleucel or standard care in lenalidomide-refractory multiple myeloma. N Engl J Med. 2023;389(4):335-347. doi:10.1056/NEJMoa2303379.

[7] U.S. Food and Drug Administration. ABECMA (idecabtagene vicleucel): prescribing information and indications. Silver Spring, MD: U.S. Food and Drug Administration; 2026.

[8] U.S. Food and Drug Administration. CARVYKTI (ciltacabtagene autoleucel): prescribing information and indications. Silver Spring, MD: U.S. Food and Drug Administration; 2026.

These expanded indications have increased the number of patients who may be considered for CAR-T and have made the timing of patient identification and referral an increasingly important component of myeloma care.

The CAR-T landscape continues to evolve, with additional cellular therapies in clinical development and regulatory review that may further expand treatment options for patients with multiple myeloma.[9, 10] As CAR-T moves earlier in the treatment continuum, decisions surrounding patient identification, timely referral, disease control during manufacturing, T-cell collection, bridging therapy, treatment readiness, and coordination between CAR-T centers and referring practices all influence the ability of patients to receive therapy when clinically appropriate.[11, 12]

The availability of multiple immunotherapies also makes sequencing an increasingly important consideration, with treatment history, disease characteristics, prior exposure to T-cell-redirecting therapies, and potential future treatment options influencing decisions about when and how CAR-T is incorporated into a patient's treatment plan.[13]

The increasing use of CAR-T also extends the responsibilities of the care team beyond treatment administration. Consensus recommendations emphasize multidisciplinary care, monitoring for acute and delayed toxicities, response assessment, infection prevention, supportive care, and long-term follow-up.[14, 15] As more patients receive CAR-T and transition between specialty centers and community-based care, effective communication, clear roles and responsibilities, and coordinated follow-up become increasingly important to support continuity of care.[16, 17]

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[9] Parikh RH, Lonial S. Chimeric antigen receptor T-cell therapy in multiple myeloma: a comprehensive review of current data and implications for clinical practice. CA Cancer J Clin. 2023;73(3):275-285. doi:10.3322/caac.21771.

[10] Hu Y, Xie Y, Wang X, et al. Targeting BCMA in multiple myeloma: designs, challenges, and future directions. Cancer Immunol Immunother. 2025;74(3):77. doi:10.1007/s00262-024-03913-0.

[11] Lin Y, Qiu L, Usmani S, Chng WJ, Costa L, Derman BA, et al; International Myeloma Working Group Immunotherapy Committee. Consensus guidelines and recommendations for the management and response assessment of chimeric antigen receptor T-cell therapy in clinical practice for relapsed and refractory multiple myeloma: a report from the International Myeloma Working Group Immunotherapy Committee. Lancet Oncol. 2024;25(8):e374-e387. doi:10.1016/S1470-2045(24)00094-9.

[12] Chari A, Costello C, Krishnan A, Patel K, Banerjee R, Berdeja JG, et al. Integrating recent evidence and expert perspectives into the management of multiple myeloma: consensus recommendations from the 2025 Bridging the Gaps Conference. Am J Hematol. 2026;101(7):1676-1686. doi:10.1002/ajh.70339.

[13] Costa LJ, Banerjee R, Mian H, Weisel K, Bal S, Derman BA, et al; International Myeloma Working Group Immunotherapy Committee. International Myeloma Working Group immunotherapy committee recommendation on sequencing immunotherapy for treatment of multiple myeloma. Leukemia. 2025;39(3):543-554. doi:10.1038/s41375-024-02482-6.

[14] Lin Y, Qiu L, Usmani S, et al. Consensus guidelines and recommendations for the management and response assessment of chimeric antigen receptor T-cell therapy in clinical practice for relapsed and refractory multiple myeloma: a report from the International Myeloma Working Group Immunotherapy Committee. Lancet Oncol. 2024;25(8):e374-e387. doi:10.1016/S1470-2045(24)00094-9.

[15] Ludwig H, Terpos E, Van De Donk N, Mateos MV, Moreau P, Dimopoulos MA, Delforge M, Rodriguez-Otero P, San-Miguel J, Yong K, Gay F. Prevention and management of adverse events during treatment with bispecific antibodies and CAR T cells in multiple myeloma: a consensus report of the European Myeloma Network. The Lancet Oncology. 2023 Jun 1;24(6):e255-69.

[16] Lin Y, Qiu L, Usmani S, et al. Consensus guidelines and recommendations for the management and response assessment of chimeric antigen receptor T-cell therapy in clinical practice for relapsed and refractory multiple myeloma: a report from the International Myeloma Working Group Immunotherapy Committee. Lancet Oncol. 2024;25(8):e374-e387. doi:10.1016/S1470-2045(24)00094-9.

[17] Chari A, Costello C, Krishnan A, Patel K, Banerjee R, Berdeja JG, et al. Integrating recent evidence and expert perspectives into the management of multiple myeloma: consensus recommendations from the 2025 Bridging the Gaps Conference. Am J Hematol. 2026;101(7):1676-1686. doi:10.1002/ajh.70339.

Long-term outcomes are also adding important context to discussions about the potential role of CAR-T earlier in the treatment journey. At the 2026 International Myeloma Society Annual Meeting, five-year follow-up from CARTITUDE-2 Cohort A showed that 10 of 20 patients remained alive and progression-free without additional anti-myeloma treatment five years after a single CARVYKTI infusion. The reported five-year overall survival rate was 69.2%, with a median progression-free survival of 60.5 months.[18] Although these data represent a small cohort, they add to the growing body of evidence regarding durable treatment-free remission following CAR-T and provide additional perspective as clinicians consider the potential benefits of using CAR-T earlier in the treatment course.

These findings complement longer-term results from CARTITUDE-1, in which a subset of patients remained alive and progression-free at five years following a single cilta-cel infusion without maintenance therapy.[19] Together, such findings are contributing to broader consideration of whether durable treatment-free remission, and potentially cure in a subset of patients, may become an achievable goal in multiple myeloma.[20]

On July 30, 2026, the International Myeloma Foundation (IMF) convened a roundtable discussion of eight members of the IMF Nurse Leadership Board, including two moderators, to examine best practices in CAR-T care from the perspective of experienced myeloma nurses. The discussion explored approaches to identifying patients who may benefit from CAR-T earlier in their treatment journey, timely referral and treatment readiness, shared-care models and coordination across care settings, operational and logistical barriers to treatment, and strategies for long-term patient management following CAR-T.

Drawing on their frontline experience in myeloma care, participants shared practical approaches for recognizing potential CAR-T candidates, strengthening communication and coordination between CAR-T centers and referring practices, addressing barriers that may delay treatment, and supporting patients throughout the CAR-T care continuum.

The discussion was guided by the following objectives:

1. Understand current approaches to identifying patients who may benefit from CAR-T therapy earlier in their treatment journey.
2. Explore best practices for shared care models and care coordination throughout the CAR-T care continuum.
3. Identify operational, logistical, and system-level opportunities to improve timely access to CAR-T therapy.
4. Discuss strategies for long-term patient management following CAR-T.

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[18] Johnson & Johnson. Single infusion of CARVYKTI® (ciltacabtagene autoleucel) delivered five-year treatment-free remissions in 50% of patients in early-line relapsed/refractory multiple myeloma. September 25, 2026.

[19] Jagannath S, Martin TG, Lin Y, Cohen AD, Raje N, Htut M, et al. Long-term (≥5-year) remission and survival after treatment with ciltacabtagene autoleucel in CARTITUDE-1 patients with relapsed/refractory multiple myeloma. J Clin Oncol. 2025;43(25):2766-2771. doi:10.1200/JCO-25-00760.

[20] Mohty M, Malard F, Facon T, Harousseau JL. Toward a cure for multiple myeloma within a decade. Blood Cancer J. 2026;16(1):33. doi:10.1038/s41408-026-01461-7.

INTRODUCTION

The emergence of BCMA-directed chimeric antigen receptor T-cell (CAR-T) therapy has transformed the treatment landscape for patients with multiple myeloma, offering the potential for deep and durable responses after a single treatment course. Early studies of ABECMA® (idecabtagene vicleucel; ide-cel) and CARVYKTI® (ciltacabtagene autoleucel; cilta-cel) demonstrated substantial activity in patients with heavily pretreated relapsed or refractory disease.[21, 22] Subsequent phase 3 studies demonstrated improved progression-free survival with ide-cel and cilta-cel compared with standard regimens in patients treated after multiple prior lines, including patients with triple-class-exposed disease and patients with lenalidomide-refractory disease after one to three prior lines.[23, 24]

These findings have contributed to the movement of CAR-T from a treatment considered primarily in later lines toward earlier consideration for appropriate patients. At the same time, the durability of responses observed with CAR-T and other modern therapies has contributed to growing discussion of sustained treatment-free remission and the possibility that some patients may ultimately achieve a functional cure.[25, 26, 27]

This shift changes the practical question for clinicians. Rather than waiting until later in the treatment course, clinicians increasingly need to recognize potential CAR-T candidates early enough to allow meaningful evaluation, referral, and planning.[28] The FDA-approved indications for the two products differ, making familiarity with product-specific eligibility requirements important when considering referral.[29, 30] At the same time, treatment eligibility is only one component of readiness. Disease control, performance status, comorbidities, organ function, infection risk, and treatment-related logistical considerations can all influence patient selection and readiness to proceed through the CAR-T pathway.[31]

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[21] Munshi NC, Anderson LD Jr, Shah N, Madduri D, Berdeja J, Lonial S, et al. Idecabtagene vicleucel in relapsed and refractory multiple myeloma. N Engl J Med. 2021;384(8):705-716. doi:10.1056/NEJMoa2024850.

[22] Berdeja JG, Madduri D, Usmani SZ, Jakubowiak A, Agha M, Cohen AD, et al. Ciltacabtagene autoleucel, a B-cell maturation antigen-directed chimeric antigen receptor T-cell therapy in patients with relapsed or refractory multiple myeloma (CARTITUDE-1): a phase 1b/2 open-label study. Lancet. 2021;398(10297):314-324. doi:10.1016/S0140-6736(21)00933-8.

[23] Rodriguez-Otero P, Ailawadhi S, Arnulf B, Patel K, Cavo M, Nooka AK, et al. Ide-cel or standard regimens in relapsed and refractory multiple myeloma. N Engl J Med. 2023;388(11):1002-1014. doi:10.1056/NEJMoa2213614.

[24] San-Miguel J, Dhakal B, Yong K, Spencer A, Anguille S, Mateos MV, et al. Ciltacabtagene autoleucel or standard care in lenalidomide-refractory multiple myeloma. N Engl J Med. 2023;389(4):335-347. doi:10.1056/NEJMoa2303379.

[25] Berdeja JG, Madduri D, Usmani SZ, Jakubowiak A, Agha M, Cohen AD, et al. Ciltacabtagene autoleucel, a B-cell maturation antigen-directed chimeric antigen receptor T-cell therapy in patients with relapsed or refractory multiple myeloma (CARTITUDE-1): a phase 1b/2 open-label study. Lancet. 2021;398(10297):314-324. doi:10.1016/S0140-6736(21)00933-8.

[26] Mohty M, Malard F, Facon T, Harousseau JL. Toward a cure for multiple myeloma within a decade. Blood Cancer J. 2026;16(1):33. doi:10.1038/s41408-026-01461-7.

[27] Banerjee R. CAR-T therapy is the preferred option in relapsed/refractory multiple myeloma. Blood Adv. 2026;10(19):6582-6584. doi:10.1182/bloodadvances.2026019898.

[28] Lin Y, Qiu L, Usmani S, et al. Consensus guidelines and recommendations for the management and response assessment of chimeric antigen receptor T-cell therapy in clinical practice for relapsed and refractory multiple myeloma: a report from the International Myeloma Working Group Immunotherapy Committee. Lancet Oncol. 2024;25(8):e374-e387. doi:10.1016/S1470-2045(24)00094-9.

[29] U.S. Food and Drug Administration. ABECMA (idecabtagene vicleucel): product information and indications. Silver Spring, MD: FDA; 2026.

[30] U.S. Food and Drug Administration. CARVYKTI (ciltacabtagene autoleucel): product information and indications. Silver Spring, MD: FDA; 2026.

[31] Ailawadhi S, Shune L, Wong SW, Lin Y, Patel K, Jagannath S. Optimizing the CAR T-Cell Therapy Experience in Multiple Myeloma: Clinical Pearls From an Expert Roundtable. Clin Lymphoma Myeloma Leuk. 2024;24(5):e217-e225. doi:10.1016/j.clml.2024.01.014.

The timing of referral is particularly important because CAR-T treatment involves multiple steps between identifying a potential candidate and administering therapy. Evaluation at a CAR-T center may include confirmation of eligibility, assessment of disease status and fitness, laboratory and diagnostic testing, infectious disease evaluation, T-cell collection, manufacturing, and consideration of bridging therapy.[32] Earlier consultation can provide time to address potentially modifiable issues, establish a relationship with the CAR-T center, clarify treatment options, and navigate financial, insurance, transportation, housing, and care-partner requirements. Recent consensus recommendations have also emphasized early referral for CAR-T as treatment options expand and sequencing decisions become more complex.[33]

Earlier referral also becomes increasingly important as the number of T-cell-directed therapies available for multiple myeloma expands. The 2025 International Myeloma Working Group recommendations on immunotherapy sequencing emphasize that prior and subsequent therapies can affect the safety and efficacy of later immunotherapy and that sequencing decisions should account for patient- and disease-related factors.[34] For clinicians, this means that CAR-T evaluation increasingly needs to be considered within the context of the patient's entire treatment trajectory rather than as an isolated decision at a single point in time.

At the same time, CAR-T requires an ongoing continuum of care that extends well beyond the cellular therapy center. The unique toxicity profile of CAR-T requires coordinated monitoring and management of cytokine release syndrome, immune effector cell-associated neurotoxicity syndrome, cytopenias, infections, hypogammaglobulinemia, and other acute or delayed complications.[35] These considerations reinforce the need for clear communication and defined responsibilities between CAR-T centers and community practices.

Real-world experience also demonstrates that patients receiving CAR-T in routine practice may differ substantially from those enrolled in pivotal clinical trials. In a multicenter U.S. analysis of standard-of-care cilta-cel, 54% of treated patients would not have met CARTITUDE-1 eligibility criteria.[36] Such experience highlights the importance of individualized assessment and coordinated decision-making rather than relying solely on the characteristics of clinical trial populations.

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[32] Lin Y, Qiu L, Usmani S, et al. Consensus guidelines and recommendations for the management and response assessment of chimeric antigen receptor T-cell therapy in clinical practice for relapsed and refractory multiple myeloma: a report from the International Myeloma Working Group Immunotherapy Committee. Lancet Oncol. 2024;25(8):e374-e387. doi:10.1016/S1470-2045(24)00094-9.

[33] Chari A, Costello C, Krishnan A, Patel K, Banerjee R, Berdeja JG, et al. Integrating recent evidence and expert perspectives into the management of multiple myeloma: consensus recommendations from the 2025 Bridging the Gaps Conference. Am J Hematol. 2026;101(7):1676-1686. doi:10.1002/ajh.70339

[34] Costa LJ, Banerjee R, Mian H, Weisel K, Bal S, Derman BA, et al. International Myeloma Working Group immunotherapy committee recommendation on sequencing immunotherapy for treatment of multiple myeloma. Leukemia. 2025;39(3):543-554. doi:10.1038/s41375-024-02482-6.

[35] Lin Y, Qiu L, Usmani S, et al. Consensus guidelines and recommendations for the management and response assessment of chimeric antigen receptor T-cell therapy in clinical practice for relapsed and refractory multiple myeloma: a report from the International Myeloma Working Group Immunotherapy Committee. Lancet Oncol. 2024;25(8):e374-e387. doi:10.1016/S1470-2045(24)00094-9.

[36] Sidana S, Patel KK, Peres LC, Bansal R, Kocoglu MH, Shune L, et al. Safety and efficacy of standard-of-care ciltacabtagene autoleucel for relapsed/refractory multiple myeloma. Blood. 2025;145(1):85-97. doi:10.1182/blood.2024025945.

EARLY PATIENT IDENTIFICATION

Identifying patients who may benefit from CAR-T earlier in the course of their disease was viewed as an important opportunity to improve access and preserve treatment options. Nurse experts described increasing use of CAR-T in earlier lines of therapy, including for selected patients with high-risk disease, while noting that referral practices continue to vary among institutions and community practices. Rather than waiting until CAR-T becomes an immediate treatment need, participants emphasized the value of recognizing potential candidates based on disease trajectory, risk, treatment history, and patient-specific factors.

Disease monitoring in the community was identified as one area where opportunities for earlier identification may be missed. Participants described situations in which biochemical changes may progress between visits without being recognized promptly, particularly when patients are assumed to be doing well on maintenance or after transplant. Gaps may arise when laboratory testing is deferred because a patient is being followed at an academic center every few months, leaving longer intervals in which changes may go unnoticed. Fragmented records across laboratory, imaging, and health systems can add to the challenge, particularly when clinicians do not have a complete view of the patient's recent results.

Patient education and self-advocacy may help address some of these gaps. Nurses described encouraging patients to understand their disease, ask questions about laboratory results, and recognize when additional evaluation may be appropriate. Patients may not realize that they can request copies of their results, ask their clinicians to explain changes, or seek an expert opinion. Simply telling patients that information is available may not be sufficient; participants described practical approaches, such as helping patients access their electronic health record during a clinic visit, to make laboratory information more visible and understandable.

Support groups may offer another opportunity to reinforce disease education and awareness of treatment options. Participants noted that some patients learn about CAR-T through support groups and subsequently seek an evaluation themselves. These experiences underscore the value of providing patients with accurate information about CAR-T while encouraging discussions with their treating teams about whether and when referral is appropriate.

REFERRAL SHOULD START EARLY

Participants described a growing trend toward earlier referral for CAR-T, but the timing of referral remains inconsistent. Some centers routinely consider CAR-T at relapse, while others increasingly evaluate patients in earlier lines of therapy, particularly those with high-risk disease. Participants emphasized that referral does not represent a commitment to CAR-T. Instead, early evaluation can establish a relationship with a specialty center, clarify treatment options, and create time to address clinical and logistical considerations before a decision becomes urgent.

Several experts advocated normalizing referral to a specialty center in much the same way that referral for stem cell transplantation has become established practice. One participant described the value of viewing this as an "expert opinion" rather than a second opinion, emphasizing that specialty referral can support collaborative decision-making without implying that the community oncologist's approach is incorrect. Establishing these relationships early may also make subsequent communication between community and academic teams more efficient.

The evolving role of bispecific antibodies has added complexity to referral decisions. As community practices become more comfortable administering these therapies, clinicians may increasingly face decisions about whether to continue a bispecific antibody locally or refer a patient for consideration of CAR-T. Participants emphasized that these approaches should not necessarily be viewed as mutually exclusive and that specialty input may help inform sequencing based on disease characteristics, eligibility, treatment history, and patient preferences. Increasing familiarity with newer therapies in the community may eventually reduce some referrals, making intentional efforts to normalize early specialty evaluation even more important.

Participants also identified assumptions on the part of clinicians and patients as potential barriers to referral. Community clinicians may assume that a patient is unwilling to travel, would not want an expert opinion, or is not fit enough for CAR-T without directly discussing those issues with the patient. Conversely, some patients actively seek CAR-T after learning about it through support groups or other sources. Direct conversations can help distinguish actual patient preferences and circumstances from assumptions and give patients an opportunity to participate meaningfully in decisions about referral.

READINESS REQUIRES TIME

Early referral also creates an opportunity to assess and optimize a patient's readiness for CAR-T before treatment becomes time-sensitive. Participants discussed the importance of considering cumulative treatment exposure, comorbidities, functional status, and T-cell health when determining whether and when a patient should proceed. The nurses said that collecting T cells earlier may be advantageous in some patients, particularly before extensive treatment has affected T-cell quality or quantity.

The collection and manufacturing process adds another layer of timing considerations. Participants noted that often it takes several weeks between collection and treatment, during which product availability, pre-testing, and other requirements must be coordinated. They also noted that treatment history and coordination of ongoing therapy may influence the ability to collect T cells effectively.

Manufacturing is not guaranteed and preserving an opportunity for improving successful collection can be an important consideration in the timing of referral. There was agreement among the nurses that they have seen a smaller percentage of manufacturing failures recently.

Early evaluation can also provide time to address administrative requirements. Participants described financial clearance and payer processes as potential sources of delay and noted that preparing a letter of medical necessity early may be easier when the patient is not yet in need of treatment on an urgent basis. Completing pre-testing and other requirements in advance can similarly reduce the number of issues that must be resolved once a treatment decision has been made.

Early referral, therefore, creates time to evaluate eligibility, optimize readiness, address logistical and administrative requirements, and establish a coordinated treatment plan before CAR-T becomes an immediate need. The nurse experts recommend this approach as it allows specialty expertise to be incorporated while patients and their care teams retain flexibility as disease status, treatment response, and available treatment options evolve.

Access Takes Coordination

Access to CAR-T depends on more than determining clinical eligibility. Participants described geographic, logistical, financial, and care partner considerations that can affect whether a patient is able to proceed with treatment at a specialty center. Travel distance may be substantial, and patients may need reliable transportation, temporary housing, and a care partner or other support during portions of the treatment and recovery period. These requirements can be particularly challenging for patients who live far from a CAR-T center or have limited financial or social resources.

Care partner availability was viewed as an important consideration that should be assessed early rather than addressed only after a patient has been referred. Participants described patients who lacked a reliable care partner or who had difficulty arranging transportation and housing. Older patients may require additional preparation and support, while language needs, medication management, consent, and other practical considerations may add complexity.

Multiple barriers can compound one another, making it important to evaluate the patient's circumstances as part of the referral process rather than treating clinical eligibility as the only determinant of access.

Geographic availability of CAR-T centers was also discussed as a practical limitation. Participants noted that patients in some regions may need to travel considerable distances because specialty centers are not evenly distributed. The experience of community clinicians with CAR-T can also vary depending on proximity to a treatment center and the number of patients they have previously managed. These differences reinforce the importance of communication between specialty and community teams before, during, and after treatment.

When feasible, components of care may be coordinated locally. Participants described the use of community-based treatment for bridging therapy in appropriate circumstances, while noting that the specific approach depends on the patient and treatment plan. They also described community clinicians reaching out to specialty centers when deciding between therapies such as bispecific antibodies and CAR-T. This type of collaboration allows treatment to remain responsive to the patient's needs while maintaining access to specialized expertise.

Role of Coordinators

Dedicated cellular therapy coordinators were viewed as an important operational resource for keeping patients moving through the CAR-T pathway. Participants described coordinators managing many of the logistical steps between referral, evaluation, collection, manufacturing, and treatment. In some institutions, transplant and cellular therapy coordination functions are closely integrated, allowing patients who have previously undergone transplantation to maintain relationships with familiar coordinators when they later pursue CAR-T.

These established relationships can also make the referral process more efficient. Rather than entering an entirely new system at the point when CAR-T becomes necessary, patients who have been evaluated earlier may already have a specialty team and coordinator familiar with their history. Participants noted that this can be particularly valuable when specialty physicians have limited appointment availability. Maintaining a relationship with the center before an urgent need arises may allow patients to be seen more quickly when treatment decisions become time-sensitive.

Capacity Matters

Specialty-center capacity can also influence how quickly patients gain access to evaluation. Participants described situations in which referring clinicians wanted to send patients for CAR-T evaluation but were told that new-patient appointments were several months away. In these circumstances, clinicians may need to begin another treatment while waiting for the specialty evaluation, potentially changing the treatment sequence before the patient can be assessed for CAR-T.

Some centers have sought to improve access by expanding the number of clinicians involved in initial evaluations, including advanced practitioners, rather than relying exclusively on a limited number of myeloma-specific specialists. Participants also described the value of having cellular therapy specialists who can evaluate patients when a myeloma-specific CAR-T specialist is not immediately available. Multidisciplinary review can then help ensure that treatment decisions remain connected to the appropriate disease expertise.

Operational capacity extends beyond clinic appointments. Participants described the need to coordinate apheresis availability, manufacturing slots, bridging therapy, inpatient beds, and outpatient monitoring capacity. As more CAR-T care moves into outpatient settings, evaluation and infusion resources may also become increasingly important. Maintaining sufficient capacity across these interconnected services can help prevent delays at one stage from affecting the entire treatment pathway.

Address Access Barriers

Practical barriers can continue to affect CAR-T care well beyond the initial referral and treatment decision. Participants described site-of-care restrictions as an ongoing challenge, particularly when supportive treatments such as IVIG cannot be administered at a convenient local facility. In some cases, patients may be required to travel considerable distances for care that could otherwise be provided closer to home, adding burden for both patients and care teams.

Insurance requirements can further complicate access. Nurse experts described spending substantial time communicating with payers, obtaining authorization, and conducting peer-to-peer discussions when coverage for post-CAR-T care or supportive therapies is questioned. These administrative requirements can delay care and place a significant burden on clinical staff. Participants noted that payer education may represent an opportunity to improve understanding of CAR-T and its associated supportive care needs, particularly when coverage decisions do not reflect the clinical judgment of the treating team.

Reducing these barriers may require greater alignment among specialty centers, community practices, payers, and other stakeholders involved in CAR-T care. Clear documentation of treatment history and clinical need can support authorization processes, while direct communication with payers may help address recurring coverage challenges. Improving the ability to provide appropriate components of care closer to home may also reduce unnecessary travel and make long-term management more sustainable.

Support Determines Access

Social and logistical support remains an important consideration throughout the CAR-T journey. Participants identified housing, transportation, and availability of a reliable care partner as ongoing challenges, particularly for patients who must travel for treatment or follow-up. Although social workers and other support resources can help address these needs, participants noted that identifying available support may require looking beyond the person who routinely accompanies a patient to appointments.

Patients may have family members or other potential sources of support who are not immediately apparent to the care team. Participants described situations in which patients routinely arrived at appointments alone despite having extended family or other potential resources. Asking more directly about a patient's support network may therefore reveal options that can help address practical requirements for CAR-T and reduce assumptions about what a patient can or cannot manage.

NURSES CONNECT CARE

Nurses were viewed as an important link across the CAR-T care continuum, from identifying potential candidates to educating patients, coordinating referrals, and supporting communication between community and specialty practices. Participants described nurses as trusted members of the care team who may recognize concerns or questions that patients do not raise with other clinicians. Their role can extend beyond treatment administration to helping patients understand their disease, navigate referrals, and advocate for themselves.

Community and academic nurses also contribute to the development of stronger working relationships between care settings. Participants described community clinicians seeking informal guidance from specialty teams regarding younger patients, treatment decisions, and the use of newer therapies. At the same time, nurses at academic centers are increasingly gaining experience with CAR-T and bispecific antibodies as more treatment moves into outpatient settings. This growing familiarity can strengthen the ability of nurses to educate patients and community colleagues about what to expect from CAR-T.

Patient education was considered particularly important when patients are evaluating whether to pursue CAR-T. Understanding how CAR-T works, the treatment process, potential toxicities, and the reasons for considering treatment at a particular point in the disease course can help patients participate more fully in decision-making. Education can also address misconceptions, including the belief that a patient must have undergone transplant before CAR-T can be considered.

Nurses can further support self-advocacy by encouraging patients to understand their laboratory results and treatment history, ask questions, and seek additional expertise when appropriate. Participants described support groups as another setting in which patients can learn about CAR-T and become more comfortable discussing referral with their treating teams. These educational efforts do not replace clinical decision-making, but they can help patients engage more confidently in conversations about their options.

Prepare Community Teams

Community clinicians may also need greater clarity about the practical requirements of CAR-T. Participants described questions from community providers about housing, care-partner requirements, expected treatment timelines, and other logistical considerations. Providing this information earlier can help referring teams have more informed conversations with patients and identify potential barriers before referral becomes urgent.

Education needs to extend beyond physicians. Participants identified nurses and advanced practitioners as important audiences because community teams may increasingly care for patients before referral and after they return home. As CAR-T becomes more established, clinicians who do not routinely administer cellular therapies may encounter patients with questions about treatment, monitoring, and long-term management.

Expand Practical Education

Ongoing education was viewed as an important way to strengthen the broader care network. Participants described nurses as highly motivated to continue learning about CAR-T, while also noting that clinical demands can make formal education difficult to attend. Continuing education programs, regional or local educational activities, and focused discussions within clinics and infusion areas may provide practical opportunities to build knowledge.

Informal education can also play an important role. Participants described advanced practitioners and other experienced clinicians teaching colleagues through case-based discussions and questions that arise during patient care. Although this approach may not reach every member of the team, it can reinforce learning in the context of actual clinical situations.

As CAR-T use expands, providing education that is relevant to both specialty and community settings may help clinicians recognize appropriate candidates, understand the referral process, anticipate practical requirements, and support patients throughout treatment. Strengthening this broader network of knowledge can complement improvements in scheduling and coordination and help make timely CAR-T access more achievable.

TRANSITIONS NEED CLARITY

The transition between specialty and community care was identified as an important area for improvement, particularly after CAR-T. Participants described situations in which community clinicians may be uncertain about which laboratory values to monitor, how long supportive medications should continue, or how follow-up should be structured after treatment. These challenges may be amplified when community APPs care for patients who received CAR-T at multiple specialty centers, each with somewhat different practices.

Regular follow-up from the specialty center can help maintain continuity, particularly because patients may otherwise fall out of the follow-up schedule once they return to local care. Participants described follow-up models that included scheduled visits every few months and, when appropriate, virtual appointments. At the same time, community care can reduce the burden of repeated travel when local clinicians have clear guidance and an established relationship with the specialty team.

Written guidance was viewed as an important component of successful transitions. Participants described the value of clear follow-up instructions addressing laboratory monitoring, supportive care, immunizations, medications, and other post-CAR-T considerations. Patient-held records and calendars may provide an additional reference for patients and care partners, particularly when care is received across multiple health systems. Clear documentation can also help ensure that the patient's community team understands not only what should be done, but when and why recommendations may change.

Electronic health records can support communication but do not eliminate the need for direct coordination. Participants noted that records may remain fragmented across systems, laboratory results may be delayed or released at different times, and simply transferring a treatment plan may not provide enough context. Direct communication between teams remains important when questions arise or when responsibility for a component of care shifts from the specialty center to the community.

The need for greater consistency was particularly apparent in long-term management. Participants described community clinicians seeking guidance about laboratory monitoring and supportive care after CAR-T, while specialty teams recognized that patients may have different follow-up expectations depending on where they received treatment. Standardized guidance, clear handoffs, defined responsibilities, and ongoing communication can help reduce this variability while allowing patients to receive appropriate portions of their care closer to home.

Tools Support Collaboration

Practical tools can help translate recommendations from the CAR-T center into consistent care in the community. Nurse experts described using detailed clinic notes, standardized letters, order plans, and direct communication to clarify recommendations for laboratory monitoring, supportive care, medications, and follow-up. Rather than relying solely on broad guidelines, providing specific recommendations within the patient's care plan can help community clinicians understand how the specialty team approaches ongoing management while allowing appropriate clinical judgment.

Direct communication between teams was viewed as particularly valuable when patients are receiving care far from the CAR-T center. Participants described using phone calls, email, virtual visits, and direct contact between nurses, advanced practitioners, and physicians to address questions and coordinate care. Establishing these relationships before problems arise can make it easier to resolve issues when they occur and may reduce the risk that patients become disconnected from either care team. Community pharmacists and other members of the local care team can also contribute to carrying out recommendations when they understand the treatment plan.

Patient and care partner resources represent another opportunity to strengthen continuity. Nurse experts identified a need for updated educational materials that explain CAR-T treatment, the transition between specialty and community care, and the ongoing responsibilities of patients and care partners after treatment.

Written resources can reinforce verbal instructions and give patients a reference when they are unsure when to return, which medications or laboratory tests are needed, or which team to contact with questions. Keeping these materials current is particularly important as CAR-T moves into earlier lines of therapy and the treatment landscape evolves.

Education can also help patients feel more comfortable seeking additional expertise when appropriate. Nurses described encouraging patients to view a second opinion as an opportunity to expand their care team rather than as a criticism of their treating clinician. This message can be particularly important for patients who may hesitate to ask questions or seek another opinion because they are concerned about offending their physician. Support group resources and patient education materials from trusted organizations can further reinforce these conversations and help patients become more informed participants in their care.

The nurse experts emphasized that effective collaboration depends on more than transferring information from one setting to another. Clear recommendations, direct communication, updated patient education, and established relationships can create a more coordinated approach to long-term CAR-T care. These tools can support community clinicians in managing appropriate aspects of follow-up while maintaining the connection to specialty expertise when additional guidance is needed.

LONG-TERM CARE

Long-term management after CAR-T remains an area of considerable practice variation, particularly around infection prevention, IVIG use, vaccination, and follow-up. Nurse experts described differences in how clinicians determine when to start or discontinue IVIG, which laboratory thresholds to use, and how long supportive therapies should continue. These decisions may also require ongoing reassessment rather than relying on a single laboratory value or time point.

Infection prevention requires continued attention beyond the initial post-CAR-T period. Participants discussed the need to establish clear criteria for IVIG and to monitor immunoglobulin levels over time, particularly because levels may change after therapy is discontinued. Antiviral prophylaxis was also identified as an important consideration, with patient education needed to reinforce that receiving a vaccination does not necessarily mean other preventive medications can be stopped. Variation in these practices can create uncertainty for both clinicians and patients, and the participants highlighted the need for consistent institutional guidance.

Follow-up also needs to extend beyond the period when patients are receiving intensive post-CAR-T care. Nurse experts described using scheduled virtual or in-person visits at approximately 3 and 6 months and continuing follow-up at longer intervals as appropriate.

These contacts provide opportunities to review laboratory results, assess ongoing infection risk, monitor disease status, and reinforce recommendations for vaccination and supportive care. Continued follow-up may also help address a potential misconception among patients that achieving a durable response means that ongoing specialty care is no longer necessary.

Guidelines can provide a framework for post-CAR-T management, but participants noted that recommendations may be interpreted differently in practice, particularly when specific thresholds or durations of therapy are not clearly defined. Even within the same institution, clinicians may make different decisions about IVIG and other supportive care measures. Developing standardized institutional protocols, while allowing for appropriate individualization, may help reduce unnecessary variation and provide clearer expectations for both clinicians and patients.

Clear delineation of responsibility between the CAR-T center and community oncology team is equally important. Participants described the need to establish who is responsible for specific aspects of care before, during, and after treatment, while recognizing the expertise and role of the referring oncologist. Strong relationships between the specialty center and community team can make these transitions more effective, particularly when clinicians communicate directly rather than relying solely on written or electronic documentation. Direct access to one another through phone or email can facilitate timely questions and help prevent patients from becoming caught between care settings.

Patient involvement can further strengthen continuity of care. Nurse experts described the importance of giving patients clear instructions about what needs to be monitored and empowering them to follow up when recommendations have not been addressed. Providing patients with a clear understanding of their ongoing care responsibilities can create an additional layer of accountability across the care team and help ensure that important aspects of long-term management are not overlooked.

Follow-Up Evolves

Long-term follow-up after CAR-T extends well beyond the immediate post-treatment period. Nurse experts generally viewed the first 3 to 6 months as a period requiring closer monitoring, followed by increasingly longer intervals between visits as patients stabilize. Continued specialty involvement remains important over subsequent years, particularly for disease monitoring, supportive care, delayed toxicities, and survivorship needs.

The intensity of follow-up may be greatest during the first several months after treatment, when patients remain at greater risk for infections, cytopenias, and other complications. Participants described seeing patients monthly during the first 3 to 4 months while allowing appropriate aspects of care, such as laboratory monitoring or IVIG administration, to occur closer to home. As patients become more stable, follow-up may transition to less frequent visits while maintaining communication between the CAR-T center and community team. Earlier reassessment may be appropriate when new symptoms or concerning laboratory findings emerge.

Survivorship Matters

Survivorship should become part of care relatively early rather than being deferred until all CAR-T-specific follow-up has ended. Participants described incorporating immunization planning, healthy lifestyle practices, and age-appropriate cancer screening into survivorship care, including encouraging patients to maintain regular follow-up with their primary care providers. Some centers have developed dedicated survivorship programs for cellular therapy patients, while others are continuing to build these services. Ensuring that survivorship clinicians understand both cellular therapy and myeloma disease monitoring remains an important consideration as these programs develop.

Delayed Toxicities Require Vigilance

The potential for delayed toxicities requires ongoing vigilance after patients transition back to community care. Although many significant complications occur earlier after CAR-T, nurse experts described the need to recognize less common or delayed events that may emerge after patients have returned to community care. Clear education about the expected timing of short- and longer-term toxicities can help patients and community clinicians recognize when symptoms warrant additional evaluation or communication with the CAR-T center.

Long-term follow-up can become more challenging when patients and clinicians interpret a durable response as meaning that CAR-T has permanently eliminated the disease. Nurse experts described patients who questioned the need for continued specialty follow-up after remaining in remission, particularly when they felt well and had returned to normal activities. Reinforcing that a durable response is an important treatment outcome while continued monitoring remains necessary can help prevent patients from becoming lost to follow-up.

Patients Need Ongoing Education

Patient education should include not only what to expect immediately after CAR-T, but also what ongoing monitoring may look like over time. Discussing the potential benefits of treatment alongside possible short- and long-term risks can help patients make informed decisions that reflect their individual goals and tolerance for uncertainty. Nurse experts also described the value of connecting patients with others who have undergone CAR-T, as peer experiences may help patients better understand the possibility of treatment-free time and what life after CAR-T can look like.

The nurse experts emphasized that long-term CAR-T care requires a coordinated approach that evolves as the patient's needs change. Early follow-up may require close specialty oversight, while later care can increasingly incorporate community oncology, primary care, and survivorship services. Maintaining clear communication, reinforcing the need for ongoing monitoring, and ensuring that patients and care partners understand their role can help preserve continuity throughout the years following CAR-T. The nurse experts emphasized that CAR-T care requires a coordinated approach that evolves as the patient's needs change.

KEY TAKEAWAYS

Nurse experts emphasized that preparing patients for CAR-T should begin well before treatment becomes an immediate consideration. Early identification and referral can create time to evaluate eligibility, consider T-cell collection, address financial and logistical requirements, and establish relationships with the CAR-T center. Importantly, referral does not commit a patient to treatment. Instead, it preserves options and allows patients and care teams to make decisions as disease status, treatment needs, and available therapies evolve.

Nurse experts also emphasized that successful CAR-T care depends on coordination across the entire care continuum. Community practices and CAR-T centers must maintain clear communication and defined responsibilities, while nurses can help connect patients and care teams, support self-advocacy, coordinate referrals, and reinforce education. Consistent handoffs and practical guidance can help address the clinical, financial, logistical, and supportive care considerations that influence a patient's ability to access and complete treatment.

As CAR-T moves earlier in the treatment journey, nurse experts identified an opportunity to shift from a reactive model, in which CAR-T is considered primarily when treatment options become limited, to a proactive model centered on early identification, readiness, and planning. Building referral pathways, care partnerships, education, and operational processes before they are urgently needed can help ensure that patients have access to CAR-T when it is an appropriate option. At the same time, maintaining clear connections between specialty and community care after treatment will be essential to support long-term monitoring, survivorship, and quality of care.

In this evolving treatment landscape, the goal is not simply to make CAR-T available, but to build a care continuum that enables patients to be identified, prepared, treated, and supported at the right time and in the right setting.

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The attendees of the IMF NLB Roundtable on July 30, 2026, were as follows:

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