PQI IN ACTION

Positive Quality Intervention

NCODA

Epcoritamab (Epkinly®) for Relapsed/Refractory Diffuse Large B-Cell Lymphoma and Follicular Lymphoma

INTRODUCTION

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

This PQI in Action is a follow up to the Epcoritamab (Epkinly®) for Relapsed/Refractory Diffuse Large B-Cell Lymphoma and Follicular Lymphoma PQI and explores how the medically integrated teams at Froedtert & Medical College of Wisconsin (Froedtert), Hematology-Oncology Associates of Central New York (HOA) and Mission Cancer + Blood collaborate and utilize the information found in the PQI as part of their daily practice.

Epcoritamab (Epkinly®) for Relapsed/Refractory Diffuse Large B-Cell Lymphoma

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CLINICAL BACKGROUND: EPCORITAMAB (EPKINLY®)

Epcoritamab-bysp (Epkinly®) is a subcutaneously administered bispecific T-cell engager that simultaneously binds to CD20 on B-cells and CD3 on T-cells. By bringing T-cells into close proximity with malignant B-cells, epcoritamab initiates T-cell–mediated cytotoxic activity, leading to lysis of tumor cells.[1,2,3]

Epcoritamab is currently approved for adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL), including high-grade B-cell lymphoma (HGBCL), after two or more prior lines of systemic therapy. It is also indicated for the treatment of relapsed or refractory follicular lymphoma (FL) in patients who have received at least two prior therapies. These approvals are based on overall response rates and durability of response.[1]

The efficacy of epcoritamab in DLBCL and HGBCL was established in the EPCORE NHL-1 trial, a multi-cohort, open-label, single-arm Phase 1/2 study. Patients were treated with a two-step-up dose regimen to mitigate risk of cytokine release syndrome (CRS). Among 148 evaluable patients, the overall response rate (ORR) was 61%, with a complete response (CR) rate of 38%. The median duration of response (DOR) was 15.6 months, with a 9-month DOR estimate of 63%. Notably, the study included a heavily pretreated population, with over 80% of patients being refractory to their most recent therapy and nearly 30% having failed prior CAR T-cell therapy.[2]

In the FL cohort of the EPCORE NHL-1 study, 127 patients received a modified three-step-up dosing schedule again to mitigate CRS risk. Preliminary data indicate an ORR of approximately 82%, with a CR rate nearing 60%, even among patients with advanced-stage disease or age greater than 65 years. These results underscore the robust efficacy of epcoritamab in a setting with limited treatment options.[3]

Epcoritamab therapy is associated with immune-mediated toxicities, most notably CRS and immune effector cell-associated neurotoxicity syndrome (ICANS). CRS occurred in approximately 50% of patients, typically during the first cycle of treatment, and was generally low-grade and manageable with supportive care, premedication, and vigilant monitoring. ICANS was observed in approximately 6% of patients, with most cases being reversible and resolving within a few days.[1,2,3]

Serious infections, cytopenias, and embryo-fetal toxicity are additional safety considerations. Prophylaxis against Pneumocystis jirovecii pneumonia (PJP) and herpes virus reactivation is recommended. Treatment interruptions or dose modifications may be required based on toxicity severity.[1]

The subcutaneous administration of epcoritamab and its favorable safety profile have enabled its integration into outpatient oncology practice. Many treatment sites have successfully implemented step-up dosing and monitoring protocols outside of the hospital setting, improving access and convenience for patients while maintaining safety. These practical advantages, combined with compelling efficacy data, establish epcoritamab as a vital option in the management of relapsed or refractory DLBCL and FL.

EPCORITAMAB PATIENT PROFILE: HCP INSIGHTS

Tara Graff, DO, MS, highlighted the dual approval as a significant advantage when considering treatment options. Graff shared, “I do really like the fact that epcoritamab does have dual indication for DLBCL and for follicular, also for our transformed lymphoma patients. I think that is really important when making a decision, especially on a follicular lymphoma patient, because a lot of times when someone recurs with follicular, they are not undergoing a repeat biopsy, which they often should because there are times in which those follicular patients could transform to higher grade lymphomas.”

Graff continued, “We know the data on transformed lymphoma with epcoritamab, and I think it is important to note that it kind of crosses a paradigm between two disease states and also the possibility of transformation. Epcoritamab is subcutaneous, which is different than its competitor, but the difference is also that it is treat to progression. That is how it was studied and that is the label.

Epcoritamab Patient Profile: HCP Insights - continued

It is not a fixed rate therapy. I find after patients have relapsed twice and are now going on to third-line therapy, they do find it comforting that they are going to be on something long-term. They almost like that safety net of knowing that if they are responding they get to stay on this."

Stephen Duffy, MD explained how the practice ensures appropriate patient selection. "We have a committee that meets once a week to look at each patient. If a physician decides they would like a patient to receive a bispecific, they put in a request for the bispecific team to review. The team makes sure the patient is appropriate both medically and as far as support goes. Not just anyone can prescribe or initiate these medications. It has to be someone in the bispecific team, and patients meet on multiple occasions with the team before starting therapy."

Together, these perspectives emphasize that epcoritamab implementation requires both careful patient selection and clear education to support informed decision-making. The combination of physician oversight, structured review processes, and patient-centered conversations ensures that individuals starting therapy understand their options and feel supported. Building on these insights, the next section explores how the medically integrated pharmacy team plays a critical role in streamlining workflows and sustaining safe, effective care delivery.

MEDICALLY INTEGRATED PHARMACY (MIP)

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

PHYSICIAN ROLE

Physicians serve as clinical champions who guide program development, treatment decisions, and patient access. Graff explained that her role as a lymphoma specialist and director of the bispecifics program ensures both scientific rigor and institutional leadership. Duffy highlighted the importance of advancing bispecific therapy in the community setting: "One of the big things in community oncology in general is getting people care close to home. The same great care they can get in big cities or academic centers." Both noted that physician engagement is essential for integrating cutting-edge therapies into routine care.

PHARMACIST ROLE

Pharmacists drive operational readiness and clinical safety. Emilie Aschenbrenner, PharmD, BCOP, described working closely with physicians to determine the appropriate setting for treatment, securing insurance approvals, and developing toxicity management guidelines. She also emphasized the role of pharmacists in building electronic alerts to ensure emergency providers have immediate access to guidance if patients present with complications. Nick Bouchard, PharmD, spoke to overseeing program expansion, noting that pharmacy leadership is essential for scaling consistent workflows across clinics. Kristin Kingma, DNP, RN, AGCNS-BC, OCN, recognized pharmacy's central role in ensuring that essential rescue medications like tocilizumab are available and that toxicity management guidelines are disseminated across urgent care and emergency departments.

NURSE ROLE

Nurses provide the patient-facing education and ongoing support that bridge clinical protocols with real-world adherence. Kingma explained, "I collaborate often with our physician partners, APP partners, and pharmacy partners, especially when we have the rollout of new medications like bispecifics, to help not only operationalize success in the

Medically Integrated Pharmacy (MIP) - continued

organization but to make sure we are following best practices." She noted the value of checklists that help nurses deliver consistent education: "What is the critical information I need to provide for these patients, to help them know how to participate in managing or monitoring for side effects?" Nurses ensure that patients and caregivers understand their role in recognizing and reporting symptoms early, which is critical to safe therapy.

PHARMACY TECHNICIAN ROLE

Pharmacy technicians ensure that therapies are prepared safely and on schedule, supporting the operational backbone of the program. Heather Bigger, CPhT, described her role in preparing medications and coordinating with procurement and scheduling: "It is a team effort all around. It comes down to the technicians making sure we are pulling out of inventory properly and preparing the drug at the time it is needed." Vincente Melende Tirado, CSPT/CPhT, emphasized the importance of training and standardization: "Any time a bispecific or any drug is introduced into the practice, we conduct training with our staff. We go over the drug, the indications, and the step-by-step instructions on how to properly mix that drug." Their work ensures accuracy, safety, and confidence across the team.

OPERATIONALIZING BISPECIFIC T-CELL ENGAGERS

CHAMPIONING BISPECIFIC T-CELL ENGAGER PROGRAMS

Successfully operationalizing a bispecific T-cell engager program requires not just protocols and checklists but committed champions who believe in the value of bringing this therapy into the community setting. Many practices describe the process as both challenging and rewarding, it requires vision, collaboration, and the willingness to learn step by step.

Dr. Graff emphasized the urgency of supporting one another in this work: "I think the time is now to band together and to learn from like-minded sites, have community groups reach out to other community groups where they've been successful to understand and figure out how to do this. The majority of patients are in the community. The ultimate goal is to keep patients at home, but always with safety first in mind. Patient want to be in their own beds and we want to give them that. We all start from a point of not knowing, but then you learn, and suddenly you're at the top of the ladder and realize, we did it."

For many practices, the momentum came from leadership. Dr. Duffy shared, "We are lucky in that it came from the top down. Our group president was at a conference where Dr. Graff was speaking about her outpatient program. He came back and said, 'We would really love to investigate this.' From there, I volunteered, and we had great pharmacists and nursing leaders who were very engaged. Right away we had a strong core of people meeting regularly, motivated to see it work. I feel very lucky to be in a practice where people are genuinely interested in these kinds of initiatives."

Together, these perspectives highlight that building a bispecific program is not about one individual, it is about cultivating a culture of shared responsibility, curiosity, and collaboration. Championing a bispecific program is only the beginning. The next step is translating that vision into a sustainable, patient-centered model of care. Doing so requires a structured approach to logistics, staffing, patient selection, and safety planning.

Dr. Graff underscored the foundation of success: "Most importantly, if a center is going to give bispecific antibodies outpatient, they need logistics in place. This includes a dedicated bispecific team of physicians, nurse practitioners, PAs, and nurses who are trained to manage these patients. Without that team, you really can't do this outpatient." She explained that protocols must extend beyond the clinic walls to include admitting privileges and hospital partnerships for rapid escalation when events like CRS or neutropenic fever occur. Equally critical is patient readiness: "It is not only education for the center, but also making sure the patient has a caregiver, social support, and the ability to safely be treated as an outpatient. Sometimes it

Operationalizing Bispecific T-Cell Engagers - continued

is not the medical comorbidities that are the barrier, but the social factors, such as no car, living too far away, or lacking a caregiver can be a non-starter."

At the practice level, many groups have created protocols and team communication pathways to ensure consistency and safety. Dr. Graff described a highly coordinated process where every patient start is shared with the bispecific team via email, complete with schedules for follow-up calls, vitals reporting, and checklists to maintain transparency across the care continuum. Ongoing education is built in, with quarterly in-services for nurses and staff to reinforce training and address turnover.

Operational adjustments also vary by geography and patient access. Kingma noted that patients in their program must live within 45 minutes of an emergency department, highlighting how regional coverage influences feasibility.

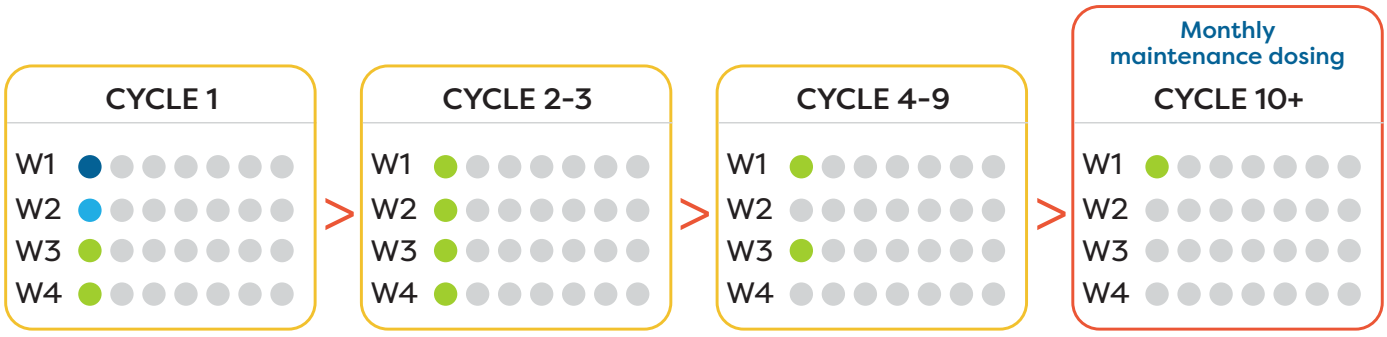
Stapleton shared that their ramp-up process initially required hospital admission for first and final step-up doses but has since evolved, with outpatient management strategies effectively reducing hospitalization. Aschenbrenner echoed the importance of coordination, explaining that their team implemented structured follow-up with in-person visits at 24 and 48 hours post-dosing, allowing them to safely transition even large B-cell lymphoma patients to outpatient care.

Multidisciplinary review is another critical safeguard. Bouchard elaborated, "We have a weekly bispecifics team meeting where we discuss all new starts, focusing on whether patients are appropriate for therapy. Do they live within an hour? Do they have the right caregivers? Pharmacists are part of this review, and by setting clear criteria up front, we've been able to treat patients safely in the outpatient setting."

Taken together, these insights show that operationalizing bispecific therapy requires more than clinical expertise. It demands infrastructure, teamwork, and a culture of communication. With strong protocols, careful patient selection, and regular education, community practices can create safe and effective pathways to keep patients close to home while accessing these innovative therapies.

> "The ultimate goal is to keep patients at home, but always with safety first in mind. Patient want to be in their own beds and we want to give them that."
>
> – Tara Graff, DO, MS

4-week dosing cycles for Epcoritamab for DLBCL



STEP-UP DOSAGE: ● **0.16 mg ON DAY 1** > ● **0.8 mg ON DAY 8**
FULL DOSE: ● **48 mg ON DAYS 15+**

Administer epcoritamab subcutaneously in 28-day cycles to well-hydrated patients until disease progression or unacceptable toxicity.

PQI PROCESS: STREAMLINING SAFE AND SUPPORTIVE EPCORITAMAB THERAPY

Safe initiation of epcoritamab requires a structured approach to prophylaxis, premedications, and monitoring to reduce the risk of adverse events. The PQI outlines critical steps that ensure patients are appropriately prepared prior to therapy.

VERIFY REQUIRED PROPHYLAXIS

- PJP prophylaxis: sulfamethoxazole/trimethoprim (800 mg/160 mg) DS one tablet orally three times per week
- HSV prophylaxis: valacyclovir 500 mg orally once daily

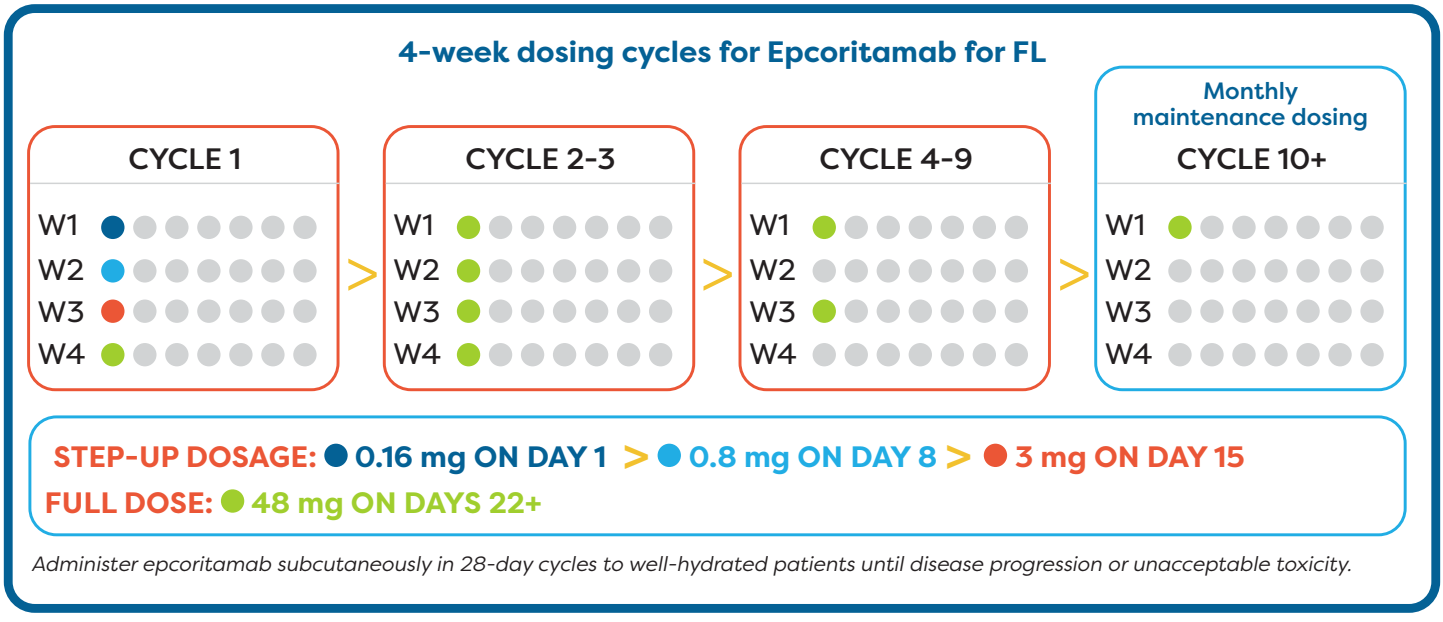
VERIFY REQUIRED PREMEDICATION

- Corticosteroid: dexamethasone 15 mg IV or PO (preferred) or prednisolone 100 mg IV or PO or equivalent, given 30–120 minutes before each weekly epcoritamab dose, and continued for three consecutive days following each weekly administration in Cycle 1
- Antihistamine and antipyretic: diphenhydramine 50 mg orally or IV (or equivalent) plus acetaminophen 650–1000 mg orally, given 30–120 minutes before each weekly administration of epcoritamab

Kingma emphasized that building these medications directly into treatment plans supports consistency and safety. "Our prophylactic and supportive medications are all built into the treatment plan. Nurses reinforce the importance of patients picking up these prescriptions before they leave, especially during step-up dosing. The risk comes when a patient does not have the medications on hand, but our infusion nurses confirm administration to prevent this gap."

Casey Stapleton, RN, described the intensity of monitoring during the ramp-up phase: "For the entire ramp-up cycle, patients come in every single day for hydration and steroids with their treatment. They receive their dose of epcoritamab, dexamethasone, and then four hours of hydration."

Bouchard explained how scheduling and additional supportive measures reduce complications: "We try to schedule everyone on a Tuesday because that works well with our bispecifics on-call team. On Monday, patients come in for fluids and steroids, then receive treatment on Tuesday with additional fluids and dexamethasone. On Wednesday, they return again for fluids and a smaller steroid dose. This allows us to assess patients frequently and catch issues early."



Administer epcoritamab subcutaneously in 28-day cycles to well-hydrated patients until disease progression or unacceptable toxicity.

CRS AND ICANS MONITORING AND MANAGEMENT

MANAGING

CRS and ICANS is central to the safe delivery of epcoritamab. The PQI outlines hospitalization for 24 hours following Cycle 1, Day 15 (first full 48 mg dose) for patients with DLBCL or HGBCL. For follicular lymphoma, hospitalization should be guided by individual patient risk factors and institutional protocols.

MONITORING RECOMMENDATIONS INCLUDE:

- CRS signs: pyrexia, hypotension, hypoxia, dyspnea, chills, tachycardia
- ICANS signs: confusion, lethargy, tremor, dysgraphia, aphasia, seizures
- Routine parameters: CBC at baseline and prior to each cycle; frequent vital signs and neurological assessments throughout treatment

Kingma highlighted the dual approach across care settings: "In the inpatient setting, our APPs and physicians are accountable for documenting CRS and ICANS using specific flow sheets in the EMR, visible in real time to the interdisciplinary team. In the outpatient setting, patients are required to return within 24 hours of each dose for nursing assessments. Nurses complete both CRS and ICANS evaluations using standardized templates, escalating any positive findings immediately to a physician or APP."

Dr. Duffy discussed preparation and clarity for providers: "We keep a spreadsheet accessible to all doctors with management criteria for CRS and ICANS. You do not want to reinvent the wheel in the middle of the night. We also map when CRS is most likely to occur after each dose. That helps distinguish between CRS and other complications such as neutropenic fever."

Stapleton described the layered monitoring process: "Every time patients come in, we complete review of systems plus targeted CRS and ICANS assessments. We include a writing sample for neuro checks. After treatment, nurses call patients that evening and the next morning to confirm they are stable. For grade 1 CRS, we use supportive medications. For grade 2, we add higher-dose steroids and consider tocilizumab. Grade 3 patients are directly admitted to the hospital."

Aschenbrenner underscored the role of internal guidelines: "We developed our own protocol that incorporates American Society for Transplantation and Cellular Therapy (ASTCT) consensus criteria, grading scales, and national guidelines. Our goal is to manage patients at home when possible, with dexamethasone, but escalate quickly to our 24-hour clinic or direct admission if needed."

Bouchard noted the importance of accessibility: "We created a grading scale for CRS and ICANS that dictates treatment steps. This document is shared across our entire organization, with physical copies provided to the on-call bispecifics team. That way, decisions can be made consistently even over the phone."

Together, these insights illustrate how practices apply national guidelines while tailoring processes to their institutional capabilities. Close monitoring, documentation, and rapid escalation pathways ensure patient safety during the highest-risk period of therapy.

Cytokine Release Syndrome

CRS is a systemic inflammatory response that can occur when the immune system is activated and releases large amounts of cytokines—proteins that help regulate immune responses.

Common Features of CRS:

Symptoms: range from mild to severe and may include:

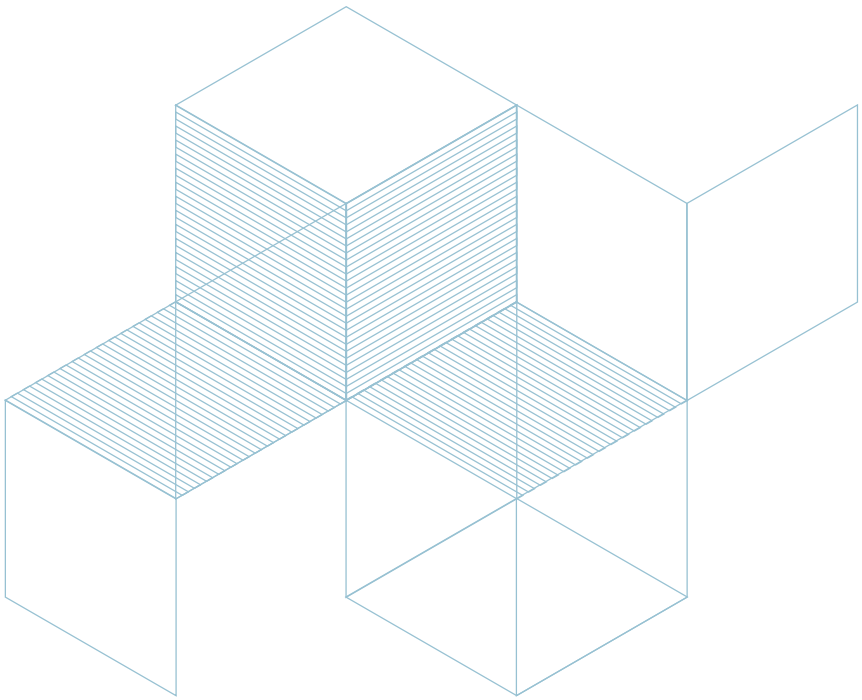
Fever	Rash
Fatigue	Shortness of breath
Nausea	Low blood pressure
Headache	Rapid heart rate

REAL-WORLD APPLICATION

Many sites administer all doses in the outpatient setting—even the first full dose for patients with DLBCL—by ensuring systems are in place for safe observation when the risks of CRS are highest.

Onset: In the EPCORE NHL-1 trial, the median time to CRS onset varied between DLBCL and FL.[3] CRS occurred approximately 24 hours after administration in patients with DLBCL, while in patients with FL, it occurred around 60 hours after administration.

Duration: In the EPCORE NHL-1 trial, the median duration of CRS was 2 days.[3]



If patients receive Cycle 1 in

Management:

Monitoring: Close monitoring of blood pressure, blood oxygen, and body temperature is essential, especially when patients are at highest risk of CRS.

Treatment Options: Treatment may include medications such as corticosteroids or tocilizumab, which can help manage inflammation and mitigate symptoms.

BEST PRACTICES

If patients receive Cycle 1 in the outpatient setting, provide them with a thermometer, pulseoximeter, and blood pressure monitor. Additionally, supply patients and caregivers with a written log or a device to record vital signs for the first 2-3 days after each Cycle 1 dose.

Immune Effector Cell-Associated Neurotoxicity Syndrome

ICANS is characterized by various neurological symptoms resulting from the activation of the immune system and the resultant inflammatory processes.

Common Features of ICANS:

Symptoms: range from mild to severe and may include:

Encephalopathy	**Motor deficits**
Headaches	**Ataxia**
Seizures	**Tremors**
Aphasia	

Onset: In EPCORE NHL-1, the onset of ICANS symptoms occurred after 2-3 weeks of therapy, and 3 days from the most recent administration.[3]

Duration: In EPCORE NHL-1, the duration was around 2-4 days.[3]

Severity: Similar to CRS, the severity of ICANS can vary significantly, with some patients experiencing mild symptoms while others may have severe or life-threatening effects.

- In EPCORE NHL-1, around 6% of patients experienced ICANS.[3]
  - The majority of cases were grade 1 or 2. There was one grade 5 ICANS event in the DLBCL group.

Management:

Monitoring: Patients receiving epcoritamab should be closely monitored for any neurological changes.

Treatment Options: Management may involve supportive care, symptom management, and potentially the use of corticosteroids or other medications to reduce inflammation.

BEST PRACTICES

If patients receive Cycle 1 in the outpatient setting, ensure that caregivers are trained to perform an ICE score, which assesses changes in speech, orientation, handwriting, attention, and receptive aphasia.

ICANS		
	DLBCL	**FL**
Onset		
From start of treatment, median	16.5 days (range: 8-141 days)	21.5 days (range 14-66 days)
From most recent administration, median	3 days (range 1-13 days)	3 days (range 0.4-7 days)
Resolution, Duration, median	90%, 4 days (range 0-8 days)	100%, 2 days (range 1-7 days)
Duration of exposure, median	5 cycles (range: 1-20 cycles)	8 cycles (range: 1-33 cycles)
All grades	6%	6%
Grade 1	4.5%	3.9%
Grade 2	1.3%	2.4%
Grade ≥ 3	0.6%	0%

COMPOUNDING AND PREPARATION

Epcoritamab requires careful handling and preparation, with requirements that vary depending on the dose. The 0.16 mg and 0.8 mg doses must be diluted according to the prescribing information, while the 3 mg and 48 mg formulations are ready-to-use. All preparation is performed in the hazardous medication room using a closed system, and vials are stored in a separate refrigerator until needed. Bigger emphasized the importance of this approach, noting, "We do make it in our hazardous rooms and use a closed system transfer device. We have a very detailed preparation and stability guide, along with a compounding and repackaging section that outlines dilution steps. The pharmacist checks each dilution before continuing on to the actual dose."

Step-up dosing presents the most complexity, as the first two doses require multiple dilutions that must be carefully performed and checked. Melendez explained, "The first two step-up doses require dilutions, whereas once the patient is on a full dose, it is just drawing up the solution from the vial, placing a subcutaneous needle on it, and it is ready. We follow our policy exactly, with labeling that forces us to review the policy each time, so we don't get into auto mode." Regardless of dose, pharmacists verify all dilutions and final products before they leave the hood. The injection is then administered subcutaneously into the abdomen or thigh, with rotation of sites and avoidance of tattoos, scars, or irritated skin.

PATIENT-CENTERED ACTIVITIES

COUNSELING & EDUCATION

Patient and caregiver education is a cornerstone of safe epcoritamab therapy. At initiation, patients and their caregivers are counseled on the risk of CRS and ICANS, the importance of promptly reporting symptoms, the step-up dosing schedule, and the hospitalization requirement for certain populations. Infection risk is also reviewed, with prophylaxis for PJP and HSV addressed, and patients are encouraged to maintain hydration before each dose.

Dr. Graff emphasized that the caregiver is as essential as the patient in this process: "We do not let a patient even start a bispecific if their caregiver is not with them from the beginning. They are present for the education on the drug mechanism, unique side effects, and neurotoxicity. We explain CRS in very simple terms, even in cartoon format, so that both patient and caregiver understand what is happening, why it occurs, and what to look for. We call them every six hours during the highest-risk days of step-up dosing, rather than relying on them to reach out to us, to keep safety at the forefront."

Other practices have implemented a variety of tools to support patient learning. Kingma described curating a one-stop educational document that pulls from manufacturer resources, wallet cards, and prescribing information, with QR codes available for quick access if materials are misplaced. "We are really good at verbalizing the education, but we are also working to reinforce it through written and electronic materials to meet patients' different learning needs," she explained.

Stapleton noted that their practice equips patients with home monitoring tools at the time of education: "At the teach appointment, we give them a pulse oximeter and an automated blood pressure cuff, and then we check on them daily after administration for three days. They must have 24/7 caregiver support and live within an hour of the office. We explain what to look for with CRS and ICANS in simple terms."

Aschenbrenner highlighted the importance of ongoing caregiver engagement: "We make sure caregivers are available for at least 48 to 72 hours after the step-up dose, checking vitals every four hours and performing neurologic assessments twice daily. Patients and caregivers must complete this education in clinic before treatment begins, and we supplement it with wallet cards, barcodes, and electronic resources."

These layered approaches, including direct education, simple explanations,

Patient-Centered Activities - continued

home monitoring, and multiple formats of reinforcement, ensure that patients and caregivers are equipped to recognize complications early and remain engaged as active partners in care.

FINANCIAL ASSISTANCE OPTIONS

Patients starting epcoritamab therapy may qualify for co-pay assistance programs through the manufacturer or third-party foundations. These resources can help reduce financial burden for patients and ensure that cost does not become a barrier to access.

From the practice perspective, careful financial planning and management are essential to maximize the potential cost savings of administering bispecific T-cell engagers in the outpatient setting. Costs extend beyond the drug itself to include administration, staff time, chair time, personnel and facility expenses, supportive medications, monitoring, and management of adverse events.

FORMULARY AND PROCUREMENT

Practices follow site-specific procedures to prepare a drug information monograph or spreadsheet for review by the Pharmacy & Therapeutics (P&T) Committee. When urgent access is required, non-formulary processes may be used. Cost, potential rebates, discounts through Group Purchasing Organizations (GPOs) or Clinically Integrated Networks (CINs), and adverse event profiles are all considered. Procurement requires coordination with specialty distributors or GPOs to ensure product availability and proper education of purchasing staff on ordering procedures. Melendez explained that once the order is placed, the drug typically arrives the next day. "We usually get the approved orders about three to four days prior to the patient's appointment, which allows us to obtain the drug on time," he said. In addition, practices make sure tocilizumab and supportive medications are on hand in case they are needed.

AUTHORIZATION AND REIMBURSEMENT

Prior to treatment, a thorough benefits investigation is performed, and prior authorization or medical exception requirements completed. Enrollment in Epkinly's MyNavCare™ Patient Support program may provide additional support for benefits investigation and prior authorization. Practices also ensure accurate billing, including J-code documentation, and maintain proactive communication with payers. Reimbursement challenges may arise with certain supportive therapies, such as prophylactic tocilizumab; practices must work through these issues on a case by case basis.

PATIENT SUPPORT RESOURCES

In addition to manufacturer-sponsored copay assistance, disease-specific foundations may offer grants or financial support. Providing patients with clear information on these resources helps minimize stress and empowers them to begin therapy without unnecessary delays. Epcoritamab is covered under the medical benefit, and follows a buy-and-bill model, making reimbursement pathways critical to program success.

CONCLUSION

THE implementation of epcoritamab highlights the essential role of structure, education, and collaboration in bringing bispecific therapy safely into outpatient practice. The PQI resource provides a concise, peer-reviewed framework that guides teams through dosing, preparation, patient education, financial considerations, and follow-up, ensuring consistency across disciplines. Utilizing the PQI resource helps practices streamline workflows, reduce variation, and maintain a strong focus on patient-centered outcomes.

As Aschenbrenner reflected, preparing for the future requires asking what each practice can realistically support and considering formulary access across regions. Kingma noted that defining the safest site of care and revisiting criteria with every patient offers ongoing opportunities for growth. Bouchard added that manufacturer partnerships and educational resources help practices stay informed and supported. These perspectives underscore that operationalizing bispecific therapy is not a one-time effort but a continuous cycle of learning and adaptation.

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Appendix: EPCORITAMAB DOSAGE AND SUPPORTIVE CARE

Each cycle is 28 days long.
Administration frequency varies depending on the cycle number.
Epcoritamab is subcutaneously administered.

Cycles 1-3:
Administered weekly

Cycles 4-9:
Administered biweekly

Cycle 10 and Beyond:
Administered once every four weeks until disease progression or unacceptable toxicity

Cycle 1 is given as a step-up dosage schedule to reduce the incidence and severity of cytokine release syndrome (CRS). The number of step-up doses are different for DLBCL and FL, where DLBCL has two step-up doses and FL has three step-up doses.

Step-Up Dosing (Cycle 1):

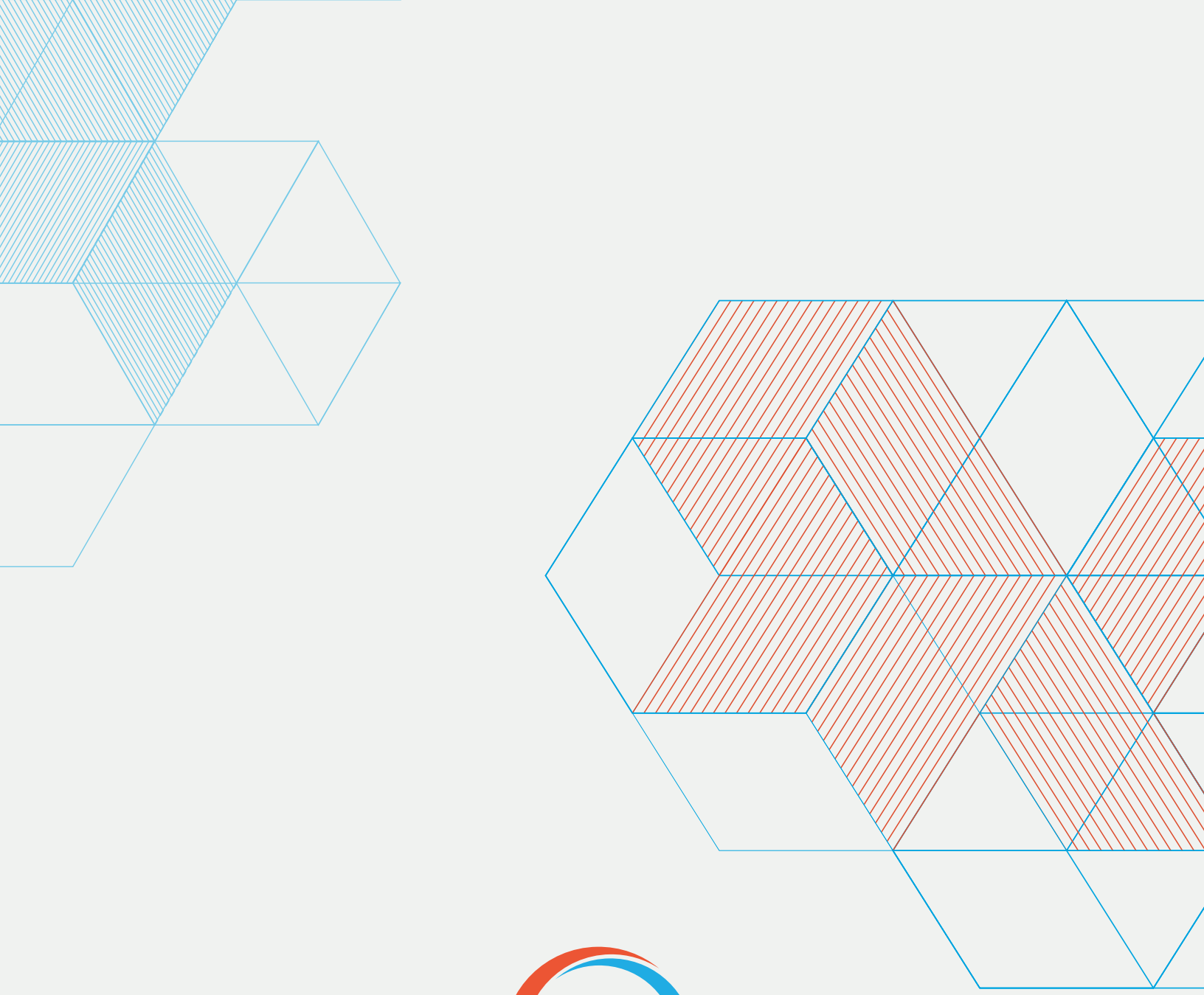
DLBCL:
Two step-up doses (0.16 mg, 0.8 mg)
First full dose (48 mg): Cycle 1, Day 15

FL:
Three step-up doses (0.16 mg, 0.8 mg, 3 mg)
First full dose (48 mg): Cycle 1, Day 22

Recommended Dosage:

Cycle of treatment (Cycle = 28 days)	Day of treatment	Dose of Epcoritamab		
			DLBCL	FL
Cycle 1	1	Step-up dose 1	0.16 mg	0.16 mg
	8	Step-up dose 2	0.8 mg	0.8 mg
	15	Step-up dose 3 or first full dose	48 mg (full dose)	3 mg (step-up dose 3)
	22	Full dose	48 mg	48 mg
Cycle 2 and 3	1, 8, 15 and 22	48 mg		
Cycle 4 to 9	1 and 15	48 mg		
Cycle 10 and beyond	1	48 mg		

Note: If a dose of epcoritamab is missed or delayed, step-up dosing may need to be restarted.



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