

BCMA Bispecifics Transition to Community Myeloma Care: EHA 2026

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The management of relapsed/refractory multiple myeloma (RRMM) has increasingly relied on novel immunotherapies, including B-cell maturation antigen (BCMA) bispecific antibodies.¹ Historically, the administration of these agents has been concentrated in academic medical centers due to complex monitoring requirements and potential for specific adverse events. The EHA 2026 presentation outlines strategies and initial outcomes for decentralizing BCMA bispecific antibody therapy, aiming to expand access to community oncology settings.

KEY TAKEAWAYS

- **The Pivot:** Strategies for community integration of BCMA bispecific antibodies for RRMM are being developed and implemented.
- **The Data:** Initial data suggests comparable safety profiles and efficacy can be maintained with appropriate protocols and training.
- **The Action:** Clinicians in community settings should prepare for the eventual integration of BCMA bispecifics into their practice, focusing on patient selection and adverse event management.

Multiple myeloma remains an incurable hematologic malignancy, with patients frequently experiencing relapse and requiring subsequent lines of therapy. BCMA-directed bispecific antibodies, such as teclistamab and elranatamab, have demonstrated substantial efficacy in heavily pretreated RRMM patients.^{1,2} These agents function by engaging BCMA on myeloma cells and CD3 on T-cells, facilitating T-cell mediated cytotoxicity. Their approval has provided new therapeutic options, but their administration has been largely confined to specialized centers due to the risk of immune effector cell-associated neurotoxicity syndrome (ICANS) and cytokine release syndrome (CRS), which necessitate close monitoring and rapid intervention.³ The EHA 2026 discussion addresses the practical challenges and proposed solutions for transitioning these therapies from academic hubs to community oncology practices, thereby improving patient access and reducing the burden of travel for ongoing treatment.

The prevalence of multiple myeloma is approximately 7.1 per 100,000 persons per year, with an increasing incidence in older populations. Many patients with relapsed/refractory multiple myeloma (RRMM) have exhausted conventional treatment options, including proteasome inhibitors, immunomodulatory drugs, and anti-CD38 monoclonal antibodies. For these patients, BCMA bispecific antibodies offer a crucial therapeutic avenue, often providing deep and durable responses. However, the geographical distribution of specialized academic centers means that a significant proportion of eligible patients, particularly those in rural or underserved areas, face considerable logistical and financial barriers to

accessing these treatments. The EHA 2026 initiative directly addresses this disparity by outlining a pathway for broader accessibility.

Strategies for Community Integration

The EHA 2026 presentation focused on several key pillars for successful integration. These included standardized protocols for patient selection, comprehensive training programs for community oncology staff, and robust adverse event management pathways. Patient selection criteria emphasize identifying individuals with adequate performance status and minimal comorbidities, ensuring they are suitable candidates for outpatient administration or local inpatient management if required.⁴ Specific considerations for patient selection include an ECOG performance status of 0-2, adequate organ function, and controlled comorbidities. Patients with active central nervous system involvement or uncontrolled infections are generally excluded.⁴ Training initiatives involve didactic sessions, simulation exercises, and preceptorships, covering drug preparation, administration techniques, and the recognition and grading of CRS and ICANS.⁴ These training modules are designed to be modular and scalable, allowing for adaptation to the specific needs and resources of individual community practices.

Adverse event management protocols are critical. These include clear guidelines for prophylactic measures, such as premedication with corticosteroids and antihistamines, and algorithms for managing CRS and ICANS. For CRS, this involves prompt administration of tocilizumab and corticosteroids based on severity grading. For ICANS, management ranges from supportive care to high-dose corticosteroids and, in severe cases, transfer to an academic center.⁵ The presentation highlighted the importance of a multidisciplinary team approach, involving pharmacists, nurses, and physicians, all trained in the specific requirements of BCMA bispecific antibody therapy.⁴ This team-based approach ensures comprehensive patient care and rapid response to potential complications.

Initial data from pilot programs presented at EHA 2026 indicated that with appropriate infrastructure and training, community centers could manage these therapies effectively. One pilot program, involving 12 community oncology practices, reported a CRS incidence of 65% (Grade 1/2) and 5% (Grade 3), with no Grade 4/5 events. ICANS occurred in 15% of patients (Grade 1/2) and 2% (Grade 3), again with no Grade 4/5 events. These rates were comparable to those observed in pivotal trials conducted in academic settings.⁶ The median time to CRS onset was 2 days, and median duration was 3 days. For ICANS, median onset was 5 days, with a median duration of 4 days. These data suggest that with vigilant monitoring and adherence to established protocols, severe complications can be mitigated in a community setting.⁶

The logistical framework for community integration also includes enhanced communication channels between community centers and their affiliated academic institutions. This ensures that expert consultation is readily available for complex cases or unexpected adverse events. Telemedicine platforms are being utilized for remote monitoring and consultation, further supporting the decentralization effort.⁴ Furthermore, patient education is a cornerstone, empowering patients and their caregivers to recognize early signs of adverse events and seek timely medical attention.⁷ While these strategies show promise, limitations include the initial investment required for training and infrastructure, and the ongoing need for robust quality control and data collection to ensure long-term safety and efficacy in diverse community settings. Continued research and real-world evidence generation will be crucial to refine these integration models.

Readers seeking foundational knowledge in clinical haematology, crucial for appreciating advancements like BCMA bispecifics, may find the Oxford Handbook of Clinical Haematology an invaluable resource.

CLINICAL IMPLICATIONS

The push to integrate BCMA bispecific antibodies into community oncology practice represents a necessary evolution in myeloma care. While the efficacy of these agents is undeniable, their restricted access due to the need for specialized management has created significant disparities. Expanding access beyond academic centers is not merely a convenience for patients, but a critical step towards equitable care, particularly for those in rural areas or with limited mobility. The initial data presented at EHA 2026, suggesting comparable safety profiles in pilot community programs, provides a cautious optimism that these therapies can be managed effectively outside of highly specialized environments, provided stringent protocols and comprehensive training are in place.

However, the transition is not without its challenges. Community practices will need to invest significantly in staff training, infrastructure, and robust adverse event management systems. The financial implications for smaller practices, particularly regarding the acquisition of necessary medications like tocilizumab and the establishment of 24/7 monitoring capabilities, cannot be underestimated. Payers and pharmaceutical companies, such as Johnson & Johnson (teclistamab) and Pfizer (elranatamab), will need to collaborate to ensure that reimbursement models support these enhanced service requirements, rather than penalizing practices for the increased complexity of care. Without adequate financial support and clear guidelines from regulatory bodies, the burden on community oncology could become unsustainable, hindering widespread adoption.

Ultimately, the success of this decentralization hinges on a sustained commitment to education and quality assurance. The emphasis on standardized protocols and continuous training is paramount. It is not enough to simply transfer the drugs; the expertise and vigilance must transfer with them. The medical community must ensure that the drive for increased access does not inadvertently compromise patient safety or dilute the quality of care. Ongoing real-world data collection will be essential to validate these initial findings and refine best practices for community-based administration of BCMA bispecific antibodies.

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