NURSE INSIGHTS ON DRUG ADMINISTRATION METHODS

Focus on On-Body Injector

Discussion with the International Myeloma Foundation Nurse Leadership Board

INTERNATIONAL MYELOMA FOUNDATION | NURSE LEADERSHIP BOARD

OVERVIEW

Advances in monoclonal antibody (mAb) therapy have significantly reshaped the multiple myeloma treatment landscape over the past decade. The first intravenous (IV) mAbs—DARZALEX®[1] (daratumumab) and EMPLICITI® (elotuzumab)[2]—received U.S. Food and Drug Administration (FDA) approval in 2015, marking a major advance in multiple myeloma therapy. CD38 emerged as a particularly valuable target because it is highly expressed on malignant plasma cells and minimally expressed on most healthy blood cells, enabling effective and well-tolerated tumor-directed activity[3]. In 2020, SARCLISA® (isatuximab) received FDA approval as an intravenous treatment,[4] and DARZALEX FASPRO® (daratumumab and hyaluronidase-fihj) was approved as the first subcutaneous (SC) formulation of daratumumab, offering an alternative to IV administration with shorter dosing times.[5] [6] Anti-CD38 mAbs such as daratumumab and isatuximab drive potent antimyeloma responses and have rapidly become foundational components of therapy.[7] Current frontline approaches frequently incorporate four-drug regimens that blend IV or SC monoclonal antibodies with oral therapies.[8] [9] [10]

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[1] https://seer.cancer.gov/seertools/seerrx/rx/564f6cc91ef557535699b3d3/

[2] Raedler LA. Empliciti (elotuzumab): First SLAMF7 antibody therapy approved for the treatment of patients with previously treated multiple myeloma. Am Health Drug Benefits. 2016;9(Spec Feature):74–77. doi:10.18553/jmcp.2016.22.9.74. PMID: 27668048; PMCID: PMC5013854.

[3] D. De Novellis, R. Fontana, V. Giudice, B. Serio, and C. Selleri, "Innovative Anti-CD38 and Anti-BCMA Targeted Therapies in Multiple Myeloma: Mechanisms of Action and Resistance," International Journal of Molecular Sciences 24, no. 1 (2023): 645, https://doi.org/10.3390/ijms24010645.

[4] FDA approves isatuximab-irfc for multiple myeloma | FDA

[5] FDA approves daratumumab and hyaluronidase-fihj for multiple myeloma | FDA

[6] Cook G, Ashcroft J, Fernandez M, Henshaw S, Khalaf Z, Pratt G, Tailor A, Rabin N. Benefits of switching from intravenous to subcutaneous daratumumab: Perspectives from UK healthcare providers. Front Oncol. 2023;13:1063144. doi:10.3389/fonc.2023.1063144

[7] Leleu, X., Martin, T., Weisel, K. et al. Anti-CD38 antibody therapy for patients with relapsed/refractory multiple myeloma: differential mechanisms of action and recent clinical trial outcomes. Ann Hematol 101, 2123–2137 (2022). https://doi.org/10.1007/s00277-022-04917-5

[8] Sonneveld P, Dimopoulos MA, Boccadoro M, Quach H, Ho PJ, Beksac M, Hulin C, et al; PERSEUS Trial Investigators. Daratumumab, bortezomib, lenalidomide, and dexamethasone for multiple myeloma. N Engl J Med. 2024;390:301-313. doi:10.1056/NEJMoa2312054

[9] Wang C, Xu Z, Jiang M, Chen Y, Lan Y. Efficacy and Safety of Isatuximab Combination Therapy in Multiple Myeloma: A Meta-Analysis of Randomized Controlled Trials. Cancers. 2025; 17(21):3494. https://doi.org/10.3390/cancers17213494

[10] Facon T, Dimopoulos MA, Leleu XP, Beksac M, Pour L, Hájek R, Liu Z, et al; IMROZ Study Group. Isatuximab, bortezomib, lenalidomide, and dexamethasone for multiple myeloma. N Engl J Med. 2024;391:1597-1609. doi:10.1056/NEJMoa2400712

On September 20, 2024, the FDA approved SARCLISA (isatuximab-irfc) in combination with VELCADE® (bortezomib), REVLIMID® (lenalidomide), and dexamethasone for adults with newly diagnosed multiple myeloma who are not eligible for autologous stem cell transplant (ASCT).[11] On January 27, 2026, the FDA expanded the indication for DARZALEX FASPRO to include transplant-ineligible newly diagnosed multiple myeloma, in addition to its prior approval in transplant-eligible patients.[12] Dara-VRd (daratumumab plus lenalidomide, bortezomib, and dexamethasone) and Isa-VRd (isatuximab plus lenalidomide, bortezomib, and dexamethasone) have become recognized as very promising induction and frontline treatments.[13] [14]

On March 27, 2026, the European Medicines Agency's (EMA) Committee for Medicinal Products for Human Use (CHMP) approved a Type II label update for subcutaneous DARZALEX allowing patients with multiple myeloma or their care partner to administer it from the fifth dose if deemed appropriate by a healthcare professional and after proper training.[15] Also, on March 27, 2026, the CHMP-EMA issued a positive opinion recommending approval of SARCLISA as a subcutaneous formulation, including administration via an on-body injector (OBI),[17] for patients with multiple myeloma.[16] Emerging delivery technologies, such as OBI, are being developed to further simplify administration and improve patient convenience while maintaining the efficacy and safety of these therapies.[18]

In a nurse preference survey, nearly all respondents favored an on-body delivery system over syringe administration when safety and efficacy were assumed equivalent.[19] Most reported it would be easy to learn and use and would improve clinic workflow. Preferences were driven by hands-free delivery, reduced physical burden, less patient discomfort with a thinner needle, lower risk of needlestick injuries, and greater overall efficiency—prioritized over injection speed.[20]

To better understand how administration methods impact nursing practice and patient experience, the International Myeloma Foundation convened a nurse roundtable on September 23, 2025. Eight members of the IMF Nurse Leadership Board, including two moderators, met to discuss real-world perspectives on current delivery modalities, with a particular focus on novel OBI technology. The conversation examined workflow logistics, patient experience, and educational priorities. Across the conversation, nurses agreed that OBI could represent a meaningful advancement, that may address practical challenges associated with traditional intravenous and subcutaneous administration and have implications for clinical staff and patients.

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[11] https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-isatuximab-irfc-bortezomib-lenalidomide-and-dexamethasone-newly-diagnosed-multiple

[12] https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-daratumumab-and-hyaluronidase-fihj-bortezomib-lenalidomide-and-dexamethasone-newly

[13] Lonial S. Is there a universal standard of care for frontline therapy in multiple myeloma? *Clin Adv Hematol Oncol*. 2025 Sep;23(6).

[14] Perrot A, Touzeau C, Lambert J, Hulin C, Caillot D, Karlin L, et al. Isatuximab, carfilzomib, lenalidomide, and dexamethasone induction in newly diagnosed myeloma: analysis of the MIDAS trial. *Blood.* 2025;146(1):52–61. doi:10.1182/blood.2024026230

[15] https://www.jnj.com/innovativemedicine/emea/media-center/press-releases/johnson-johnsons-darzalex-daratumumab-becomes-the-first-oncology-injectable-approved-for-administration-by-patients-or-caregivers

[16] https://www.sanofi.com/en/media-room/press-releases/2026/2026-03-27-12-00-00-3263711

[17] Sikander Ailawadhi et al. Isatuximab Subcutaneous by On-Body Injector Versus Isatuximab Intravenous Plus Pomalidomide and Dexamethasone in Relapsed/Refractory Multiple Myeloma: Phase III IRAKLIA Study. *J Clin Oncol* 43, 2527-2537(2025). DOI:10.1200/JCO-25-00744

[18] Parmar G, Capra M, Seguro F, et al. Efficacy and safety of isatuximab subcutaneous plus carfilzomib and dexamethasone in patients with relapsed/refractory multiple myeloma: results of the phase 2 study IZALCO. Poster presented at: ASCO Annual Meeting; May 30–June 3, 2025; Chicago, IL. IZALCO - ASCO poster link.

[19] Desai M, Faiman B, Gorski LA, et al. Evaluating nurse preferences for a novel on-body delivery system vs. manual syringes for large-volume subcutaneous drug administration: a survey study. Drug Deliv. 2025;32(1). doi:10.1080/10717544.2025.2484278.

[20] Desai M, Faiman B, Gorski LA, et al. Evaluating nurse preferences for a novel on-body delivery system vs. manual syringes for large-volume subcutaneous drug administration: a survey study. Drug Deliv. 2025;32(1). doi:10.1080/10717544.2025.2484278.

The specific objectives were to:

1. Evaluate the impact of myeloma treatment delivery methods on nurses' daily practice, with a focus on their perspectives regarding on-body injector (OBI) technology compared to traditional administration methods.
2. Gain insights into logistical considerations in myeloma treatment delivery by exploring institutional workflows and the dynamics between nursing and pharmacy teams.
3. Identify specific educational and resource needs of nursing staff and treatment centers related to the use of new OBI technology.

INTRODUCTION

Multiple myeloma represents a significant global health challenge, as it is the second most frequently diagnosed hematologic malignancy after lymphoma and ranks among the top 25 most common cancers worldwide.[21] Epidemiologic studies show that the global incidence of multiple myeloma has approximately doubled between 1990 and 2021, and projections indicate that this upward trend will continue.[22] In addition, disparities in access to care and treatment outcomes persist across regions, highlighting the need for innovations that can improve patient experiences and streamline clinical workflows.[23]

Anti-CD38 monoclonal antibodies have become central to multiple myeloma management, demonstrating efficacy across multiple lines of therapy.[24,25] Advances in therapy administration have included the development of subcutaneous formulations of monoclonal antibodies. Compared with traditional intravenous administration, SC delivery can shorten treatment duration, increase patient comfort and satisfaction, reduce resource utilization, and enhance provider workflow.[26] After its approval in 2020, DARZALEX FASPRO®, the subcutaneous formulation of daratumumab, successfully transitioned treatment from intravenous infusions, which required hours, to injections that take under 5 minutes, with the SC formulation now representing roughly 93% of daratumumab use in the United States.[27,28]

The FDA-approved subcutaneous monoclonal antibody products on the market today use fixed-dose combinations with recombinant human hyaluronidase, which temporarily breaks down hyaluronan in the extracellular matrix to allow delivery of larger SC doses than would otherwise be feasible; however, these therapies can still present challenges related to injection volume, viscosity, and solution stability.[29] As a result, administration of large-volume SC medications continues to pose physical demands for nurses, potential injection site reactions, and patient concerns regarding needle size and technique, underscoring

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[21]Mattar M, Bazarbachi A, Abduljalil O, Francis B, Alam A, Blunk V. Epidemiology, treatment trends, and outcomes of multiple myeloma in the Middle East and Africa: A systematic review. Clin Hematol Int. 2024;6(1):67-83. doi:10.46989/001c.92555. PMID: 38817690; PMCID: PMC11086989.

[22]Zhuge L, Lin X, Fan Z, et al: Global, regional and national epidemiological trends of multiple myeloma from 1990 to 2021: A systematic analysis of the global burden of disease study 2021. *Front Public Health* 13:1527198, 2025

[23]Mateos MV, Ailawadhi S, Costa LJ, et al: Global disparities in patients with multiple myeloma: A rapid evidence assessment. *Blood Cancer* J 13:109, 2023

[24]Ntanasis-Stathopoulos I, Filippatos C, Malandrakis P, Koutoulidis V, Kastritis E, Terpos E, Dimopoulos M-A, Gavriatopoulou M. Upfront Anti-CD38 Monoclonal Antibody-Based Quadruplet Therapy for Multiple Myeloma: A Systematic Review and Meta-Analysis of Clinical Trials. *Cancers*. 2025; 17(12):1943. https://doi.org/10.3390/cancers17121943

[25]van de Donk NWJC, Richardson PG, Malavasi F. CD38 antibodies in multiple myeloma: back to the future. *Blood*. 2018;131(1):13-29. doi:10.1182/blood-2017-06-740944.

[26]George S, Bourlon MT, Overman MJ, et al. Systematic literature review of intravenous versus subcutaneous administration of oncology therapies: A clinical, economic and patient perspective. *Cancer Treat Rev*. 2025;139:102974. doi:10.1016/j.ctrv.2025.102974

[27]Green P, Schneider A, Lange J. Navigating large-volume subcutaneous injections of biopharmaceuticals: a systematic review of clinical pipelines and approved products. *MAbs*. 2024;16(1):2402713. doi:10.1080/19420862.2024.2402713

[28]First Quarter 2024 Financial & Operating Results. Halozyme Corporate Presentation, Halozyme therapeutics, Inc., 2024 May 7. https://halozyme.com.

[29]Davis JD, Bravo Padros M, et al. Subcutaneous administration of monoclonal antibodies: pharmacology, delivery, immunogenicity, and learnings from applications to clinical development. *Clin Pharmacol Ther*. 2024;115(3):422-439. doi:10.1002/cpt.3150. Epub 2024 Jan 10. PMID: 38093583.

[30]Anderson MK. Optimizing subcutaneous therapy: key considerations and collaborative opportunities. NCODA. Published June 23, 2025. https://www.ncoda.org/news/optimizing-subcutaneous-therapy/
. Accessed December 8, 2025.

ongoing interest in strategies that improve both patient and provider experience.[30]

Isatuximab is FDA-approved for combination regimens in both relapsed/refractory and newly diagnosed, transplant-ineligible patients. Currently delivered intravenously, isatuximab infusion times range from approximately 75 minutes for standard dosing to shorter durations under investigation in select patient populations. SC administration of isatuximab through an innovative OBI device is under active evaluation and has the potential to address certain limitations of isatuximab IV administration or isatuximab manual push SC injection. These wearable devices enable hands-free, controlled delivery with high injection volumes, which may improve comfort while maintaining therapeutic efficacy.[31] [32] As of the time of publication, isatuximab administered subcutaneously via on body-injector (OBI) is investigational and its safety and efficacy have not been evaluated by the U.S. Food and Drug Administration or any other agency worldwide.

Studies and ongoing trials, including IRAKLIA and IZALCO, suggest that subcutaneous (SC) isatuximab delivered via an OBI maintains safety and efficacy comparable to intravenous infusion, while indicating high patient and healthcare provider preference for this modality.[33] [34]

ON-BODY INJECTION DEVICE PRODUCT OVERVIEW

The participants were provided with an OBI overview describing the device as a sterile, single-use, user-filled wearable injector housed within a filling base. The overview noted that the system contains no batteries or electronics; activation occurs by pressing a central button, which initiates SC Isa delivery and indicates completion. An adhesive backing secures the device during administration and supports removal afterward, and a viewing window allows users to monitor fill-gauge progress throughout the injection.

Image Source: Leleu X, Ailawadhi S, Špička I, et al. Isatuximab (SC via on-body delivery system) vs IV, plus pomalidomide and dexamethasone in RRMM: Results from the Phase 3 IRAKLIA study. Presented at the 2025 ASCO Annual Meeting; May 30–June 3, 2025. **IRAKLIA - ASCO** presentation link

[31]Leleu X, Ailawadhi S, Špička I, et al. Isatuximab (SC via on-body delivery system) vs IV, plus pomalidomide and dexamethasone in RRMM: results from the phase 3 IRAKLIA study. Presented at: ASCO Annual Meeting; May 30–June 3, 2025; Chicago, IL. IRAKLIA - ASCO presentation link.

[32]Parmar G, Capra M, Seguro F, et al. Efficacy and safety of isatuximab subcutaneous (SC) plus carfilzomib and dexamethasone (Isa-Kd) in patients with relapsed/refractory multiple myeloma (RRMM): results of the phase 2 study IZALCO. *J Clin Oncol*. 2025;43(16_suppl):7526. doi:10.1200/JCO.2025.43.16_suppl.752.

[33]Parmar G, Capra M, Seguro F, et al. Efficacy and safety of isatuximab subcutaneous (SC) plus carfilzomib and dexamethasone (Isa-Kd) in patients with relapsed/refractory multiple myeloma (RRMM): results of the phase 2 study IZALCO. *J Clin Oncol*. 2025;43(16_suppl):7526. doi:10.1200/JCO.2025.43.16_suppl.752.

[34]Parmar, G., Capra, M., Seguro, F. et al. Efficacy and safety of isatuximab subcutaneous plus carfilzomib and dexamethasone in patients with relapsed/refractory multiple myeloma: results of the Phase 2 study IZALCO. *Blood Cancer J.* **16**, 16 (2026). https://doi.org/10.1038/s41408-025-01436-0

Participants were also provided with key findings from the IRAKLIA study.[35] Results indicated that subcutaneous isatuximab delivered via the OBI achieved similar efficacy and comparable pharmacokinetics to isatuximab intravenous administration. The safety profile was similar between SC and IV formulations, with no new or unexpected safety signals observed. Coprimary end points were overall response rate (ORR; noninferiority margin, 0.839) and Isa Ctrough (C6D1 predose; noninferiority margin, 0.8). Noninferiority of OBI versus IV was demonstrated if both coprimary end points achieved noninferiority.

Key secondary end points were:
- Very good partial response or better (≥VGPR) rate were 46.4% for Isa OBI and 45.9% for IV
- IR incidence was 1.5% for Isa OBI and 25.0% for IV. The majority of IRs were grade 1 to 2
- Patients receiving Isa SC via OBI reported greater satisfaction with their method of administration (70%) compared with those receiving Isa IV therapy (53.4%).

Key OBI device characteristics highlighted included:[36]
- Flat dose – No adjustments for body weight
- Hands-free administration
- Hidden ~30G needle – Needle is not visible before, during, or after administration
- Lower likelihood of needle-stick injury versus IV catheters.
- No hyaluronidase required
- 10 mL injection volume
- Individualized flow rate based on subcutaneous interstitial pressure

Key findings from IRAKLIA regarding the OBI device performance included:[37]
- 99.9% of administrations with the OBI completed without interruption
- 13 minutes median duration of OBI injection
- 97.9% of OBI injections completed in under 20 minutes
- The flat dose of Isa SC OBI showed consistent overall response rate (ORR) across body weight subgroups
- Isa SC OBI showed superiority over Isa IV in incidence of infusion reactions; nearly all local injection site reactions were grade 1 and resolved within one day

Roundtable participants were also presented with highlights from the Phase 2 IZALCO study evaluating subcutaneous isatuximab plus carfilzomib and dexamethasone (Isa SC + Kd) in relapsed/refractory multiple myeloma.[38] Findings were consistent with results from IKEMA (IV Isa + Kd), demonstrating comparable efficacy. No differences in efficacy, safety, or pharmacokinetics were observed between administration via OBI and manual subcutaneous injection.

The primary endpoint was overall response rate (79.7%: P=.0043). The key secondary endpoint was patient preference for method of isatuximab SC administration: OBI or Isa manual injection. There was strong patient preference for OBI, with 74.5% of patients selecting it over manual isatuximab injection (17%). Most healthcare professionals (78.9%) also preferred the OBI. Infusion-related reactions were low overall (2.7%) and were not observed with OBI administration. Injection site reactions were infrequent with both delivery methods.

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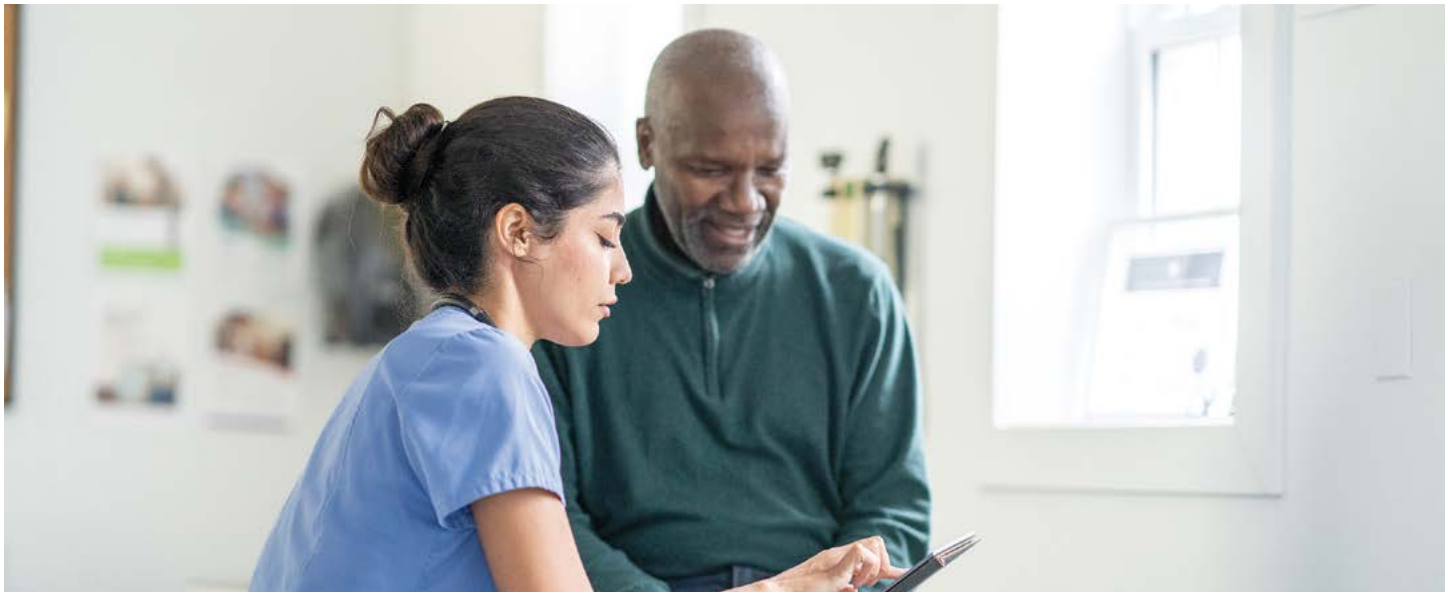
[35]Leleu X, Ailawadhi S, Špička I, et al. Isatuximab (SC via on-body delivery system) vs IV, plus pomalidomide and dexamethasone in RRMM: Results from the Phase 3 IRAKLIA study. Presented at the 2025 ASCO Annual Meeting; May 30–June 3, 2025.
[36]Leleu X, Ailawadhi S, Špička I, et al. Isatuximab (SC via on-body delivery system) vs IV, plus pomalidomide and dexamethasone in RRMM: Results from the Phase 3 IRAKLIA study. Presented at the 2025 ASCO Annual Meeting; May 30–June 3, 2025.
[37]Leleu X, Ailawadhi S, Špička I, et al. Isatuximab (SC via on-body delivery system) vs IV, plus pomalidomide and dexamethasone in RRMM: Results from the Phase 3 IRAKLIA study. Presented at the 2025 ASCO Annual Meeting; May 30–June 3, 2025.
[38]Parmar G, Capra M, Seguro F, et al. Efficacy and safety of isatuximab subcutaneous plus carfilzomib and dexamethasone in patients with relapsed/refractory multiple myeloma: results of the phase 2 study IZALCO. Poster presented at: ASCO Annual Meeting; May 30–June 3, 2025; Chicago, IL. IZALCO - ASCO poster link.



TREATMENT ADMINISTRATION: INTRAVENOUS AND SUBCUTANEOUS

During the roundtable, nurses highlighted several challenges associated with intravenous (IV) administration, including prolonged infusion times, intensive monitoring requirements, and scheduling constraints. Many noted that the higher risk of infusion-related reactions adds complexity, requiring nurses to carefully balance patient safety with competing workflow demands. In contrast, subcutaneous (SC) administration has alleviated some of these burdens by shortening chair time and simplifying patient flow, although institutional policies and limited infusion space can still affect scheduling decisions.

Efficiency and Time Savings

The nurse experts agreed that subcutaneous administration provides notable efficiency gains and reduces the risk of infusion-related reactions compared with IV therapy. They emphasized that shorter chair time benefits both patients and clinics by easing scheduling demands and improving workflow.

Physical Strain on Nurses

Participants also highlighted that manual SC injections can be physically taxing for nurses, particularly in high-volume centers. The repetitive motion required for multiple manual pushes throughout the day can potentially lead to strain and even injury.

Observed Patient Discomfort and Privacy Concerns

While discussing their clinical experience, nurses noted that some patients appear anxious during manual SC pushes, particularly when watching the nurse control the injection rate.

"It can be a real anxiety point when you have a healthcare provider next to you, and then they're just pushing... and the patient starts to think, are they pushing too fast? Are they pushing too slow?"

Participants also cited privacy concerns, as SC injections sometimes require partial exposure of the abdomen or thigh in shared spaces in addition to the nurse in very close proximity for what might feel like a long time.

"There's a privacy difference which can affect the nurse and the patient. The way our infusion rooms are set up, there is no privacy. Oftentimes, a long manual push is awkward, and not every patient's comfortable always having skin exposed."

POTENTIAL VALUE AND ADVANTAGES OF ON-BODY INJECTORS

Nurse experts characterized on-body injectors as a meaningful advancement that has the potential to address several limitations associated with both intravenous and manual subcutaneous administration. The adhesive-backed, hands-free devices provide consistent, automated medication delivery, enabling nurses to maintain clinical oversight "chair-side" rather than needing to remain continuously "bed-side" during administration. This shift was viewed as a potential important workflow advantage, allowing nurses greater flexibility to attend to other patient care activities while remaining engaged in the treatment process. As one participant summarized, "I think the hands-free is probably a big deal."

Nurses highlighted the potential impact of OBIs on patient experience, independence, and comfort. The small, concealed needle design may reduce anxiety, which is particularly important for patients who are fearful of needles, and reduce the risk of needlestick injuries. By reducing chair time compared with intravenous administration and offering predictable, standardized dosing, OBIs were described as supporting patient convenience and comfort. Nurses also appreciated having options to deliver care to patients.

Participants emphasized that adequate demonstration and hands-on education are essential to building confidence in using the device. Nurses emphasized the importance of having multiple evidence-based administration options, noting that greater flexibility allows them to better individualize care and align treatment delivery with patient needs and clinic workflow.

Operational Efficiency and Integration Needs

The nurses suggested that OBI have the potential to streamline clinic workflow. They commented that, compared to IV administration of isatuximab, OBIs have the potential to reduce pharmacy preparation time, decrease chair occupancy, and lower direct nursing time per treatment—thereby likely helping to free staff to focus on patient care and supporting an increase in the number of patients who can be treated at a given time. The nurses also believed that from the patient perspective compared to IV, this could potentially translate to shorter appointment times, less time in the clinic, and a more comfortable treatment experience.

The nurses emphasized that successful integration of OBIs requires deliberate planning and coordination among nursing, pharmacy, and administrative teams. They highlighted practical considerations such as determining appropriate storage locations for the devices and ensuring that all staff members are properly trained. They suggested establishing standardized handling and storage procedures, defining clear roles and responsibilities for device preparation and administration, and maintaining effective communication across all team members. When implemented thoughtfully, the nurses believed that OBIs could enhance operational efficiency, improve patient satisfaction, and reduce staff burden without compromising safety or treatment quality.

Community Practice Considerations

In community settings, nurses often juggle multiple roles, and the introduction of OBI was seen as a potential tool to simplify workflow and increase flexibility—provided that comprehensive training is available. One participant explained, "In the communities, though, a lot of times the nurses are the pharmacists… it makes it easier for them to do this." By reducing reliance on pharmacy for preparation and allowing hands-free delivery, OBIs could enable nurses to manage multiple patients simultaneously, improving efficiency and patient flow.

Nurses noted that workflows in community practices can vary depending on pharmacy staffing models and availability, with OBIs viewed as a potential way to expand access to therapy in settings where on-site or specialty pharmacy support may be limited. OBIs might be able to help support more flexible care delivery in these settings.

At the same time, the nurses anticipated that community-based pharmacists would likely welcome OBIs as a means of improving access and reducing preparation demands. In contrast, pharmacists in academic centers might prefer to maintain tighter oversight, viewing OBI management by infusion nurses as outside established procedures. The participants emphasized that successful adoption in any setting depends on clear training, defined workflows, and collaboration between nursing and pharmacy teams to ensure safety, efficiency, and consistent patient care.

SAFETY AND MONITORING

Confidence in Safety and Reaction Management

Nurses expressed confidence in the safety profile of OBI, noting that infusion-related reactions were rare and treatment interruptions were uncommon. They emphasized that the ability to pause or stop the device mid-delivery provided an additional safeguard, enhancing their comfort with the technology and supporting safe clinical use.

One participant remarked, “The incidence of infusion-related reaction is very small… didn’t have to interrupt the injection for very, very few, which is nice.” Another highlighted the practicality of the pause function, stating, “You could put your thumb on it and pause it and hold it.”

The nurses noted that these features—combined with the overall low frequency of adverse events—contributed to greater confidence in both patient safety and workflow efficiency. They suggested that clear communication and training around these functions are essential to reassure staff, promote consistent use, and ensure rapid response in the unlikely event of a reaction. By providing both safety and control, OBIs were seen as a tool that could streamline treatment delivery while maintaining high standards of patient care.

Maintaining Observation Protocols

Although OBI can reduce chair time versus IV, participants emphasized that maintaining appropriate patient observation remains essential, particularly during early treatment cycles or when transitioning patients from other delivery methods. Nurses highlighted that these observation periods allow for monitoring patient responses and maintaining direct engagement. As one participant explained, “I think a lot of infusion room nurses are infusion room nurses because they love the patient contact and the discussion with patients, and it gives you a chance to really learn what is going on with them.”

Nurses noted that with OBIs, they can remain nearby and attentive without needing to manually push the medication, allowing them to monitor patients while attending to other tasks. This hands-free delivery provides the flexibility to observe and respond as needed.

PATIENT EXPERIENCE

Convenience and Autonomy

The nurses agreed that patients are likely to value the reduced chair time, greater convenience, and predictability offered by OBI compared to IV administration. In addition, as anti-CD38 have evolved and there are lower rates of infusion reactions, there is the potential to eliminate pre-medications after early cycles which could further enhance patient comfort, support adherence, and improve overall satisfaction.

Nurses also highlighted the importance of the device's small, concealed needle, explaining that patients appreciate not seeing the needle before, during, or after injection, which reduces anxiety and needle-related discomfort. One nurse emphasized the value of incorporating patient perspectives in the data, stating:

"Patients have a voice in this... we don't typically see that, and I like that aspect of it in the data."

While OBIs are not yet available for home administration, the nurses suggested that extending access to the home setting would be a valuable next step. They highlighted the financial and practical advantages for patients, including reduced travel, lower parking costs, and less time away from work, which could help alleviate the economic burden often associated with clinic-based treatment.

The nurses emphasized that creating dedicated teams to manage OBIs in the home setting could transform the patient experience. Such teams would not only handle device delivery and setup but also provide education, support, and troubleshooting, ensuring safe and effective administration outside the clinic. Nurses suggested that home-based OBI programs could increase convenience, reduce the burden of frequent travel, and allow patients to maintain daily routines with minimal disruption. They believed this approach aligns with patient preferences for more personalized, flexible care and could strengthen overall satisfaction while maintaining safety and adherence.

RESOURCES, EDUCATION, AND TRAINING NEEDS

Training for Clinical Teams and Patients

The participants emphasized that successful implementation of OBI relies on comprehensive education for both clinical staff and patients. They noted that proper training not only ensures safe and effective administration but also helps build confidence and trust in the device. To support this, nurses recommended intuitive training materials that clearly outline each step of device use, including visual aids and practical demonstrations. One nurse remarked:

"Make the presentation of it as intuitive as possible, especially in the initial demonstration."

They also highlighted the importance of proactive guidance on insurance coverage and reimbursement processes. Nurses noted that unclear or complex reimbursement pathways could create a barrier to adoption if hospitals or clinics perceive the process as too complicated or time-consuming. They also stressed the importance of addressing concerns about whether insurance would reimburse at all, as uncertainty in this area could prevent clinics from offering OBI administration. Providing clear guidance on these aspects can help minimize confusion, reduce administrative workload, and ensure that patients have timely access to treatment.

Nurses expressed the need to understand and anticipate issues that might arise during administration. They were reassured to learn that in the clinical trial that the pause feature was not needed and in nearly all cases the drug was delivered correctly. Nurses felt it would be important to explain this in advance to ensure staff are prepared, avoid unnecessary concern, and maintain patient confidence in the treatment.

Overall, the nurses highlighted that structured, hands-on training, clear step-by-step guidance, and transparent communication about potential device nuances are essential to successful OBI integration in clinical practice and to fostering patient comfort and adherence.

NURSE PERSPECTIVES ON CONSIDERATIONS FOR PRACTICE CHANGE

During the roundtable, participants shared the key factors they considered when evaluating the adoption of OBI. They highlighted the importance of understanding whether OBIs could deliver consistent, reliable care across different institutions and the actual impact on daily workflow, time management, and patient engagement. The nurses emphasized that evidence of effective training was critical, demonstrating that staff could quickly gain confidence and competence in using the device after education. They also valued peer-to-peer insights, particularly from colleagues involved in trials or early implementation efforts.

The nurses noted the need for a balance between novelty, scientific value, and practical relevance in the data presented, explaining that information is more influential when it directly applies to clinical practice. One participant observed, “I think nurses want to hear from other nurses… maybe through the trial, if there were any qualitative data obtained to characterize it.”

Also, they highlighted that nurse-led publications and shared experiences were essential tools for building trust, spreading best practices, and accelerating adoption of OBIs in clinical settings. By presenting both operational and patient-centered benefits, these resources helped the nurses feel informed, prepared, and empowered to implement practice changes effectively.

NURSE INPUT AND INFLUENCE ON ADOPTION

Nurses play a critical, though sometimes indirect, role in the adoption of new therapies and administration methods. In many institutions, nurses may not become aware of emerging treatments until they are formally added to the formulary, making physician and pharmacist buy-in essential. Nursing teams can spark interest and awareness, but formal evaluation and committee approval are typically led by physicians and pharmacy. As one participant explained, "Once it's established at some institutions, word of mouth spreads to smaller community practices. Sometimes the nursing team initiates interest, but they'll want to review the data first." Another noted, "Pharmacy input is very important. Advanced practice providers and physicians typically sit on the committee that evaluates new therapies."

Beyond awareness, nurses in both community and academic settings can influence adoption through education, training programs, and advocacy. They help communicate practical benefits of new administration methods, particularly those that reduce manual effort and improve workflow. One participant described, "If you have nurses that say, 'I don't have to push it in anymore, I can just put it on the patient's skin and do other tasks,' that can influence adoption." Professional development programs also play a role: "I see this in the community practices: the office manager or nurse manager attends an ONS program and learns about the therapy. That's how SubQ Dara got added to many formularies—through the nursing voice."

Advanced practice nurses and nurse managers can further shape formulary decisions by guiding physicians and pharmacists. As one nurse practitioner stated, "As a nurse practitioner, I know I influence my formulary by influencing my physicians and pharmacists." At the same time, nurses' perceived influence varies by institution. Some feel their input on adoption decisions is limited, while others—often depending on institutional culture—believe their feedback is valued, particularly regarding nurse satisfaction, efficiency, and workflow. One participant explained, "I wouldn't say all nurses are involved equally, but most medical directors and lead physicians care about nurses being happy and effective, and about chair time and workflow."

Nurses emphasized that clear, evidence-based justification is essential for adoption decisions, including clinical outcomes, cost considerations, and operational efficiency. One participant observed, "When multiple therapeutics exist in the same space, there needs to be a clear, agreed-upon rationale—considering factors like progression-free survival, cost, or time." Demonstrating tangible workflow or operational benefits can further facilitate uptake: "If it's already on formulary, adoption is easier. Demonstrating benefits like improved chair turnover can help justify use, especially in large centers."

Overall, nurses serve as key advocates and educators in the adoption process. Their awareness, operational insight, and ability to communicate both clinical and workflow benefits can complement formal committee evaluations, ultimately helping institutions implement therapies and administration methods that improve patient care and staff efficiency.

KEY TAKEAWAYS

Nurse experts highlighted several factors that can support the effective use of OBI. The simplicity of the setup and the intuitive design were noted as important for both patients and clinical staff, helping build confidence once the device is demonstrated.

Features of OBI such as hands-free administration, a flat dose, and a small, concealed needle were valued for reducing the risk of sharps injury and for providing a more comfortable experience for patients, particularly those with needle anxiety. Quick setup and reduced chair time were also seen as contributing to smoother patient flow and operational efficiency. Including patient perspectives in data collection was recognized as a valuable approach that reinforces patient-centered care.

At the same time, nurses identified several challenges and barriers to OBI access. Concerns about the transportability and stability of the device, limited access to in-person training, and a lack of hands-on demonstrations could create hesitation among staff. Insurance and reimbursement processes were noted as potential obstacles that might delay use, particularly when staff lack time to navigate appeals. Gaining pharmacy and institutional approval was emphasized as critical but sometimes challenging, especially in large academic centers, and staff may default to established alternatives when administrative or formulary hurdles arise. In community settings, additional educational resources and practical guidance were seen as necessary to ensure consistent understanding and use.

To support successful OBI access, nurses recommended hands-on demonstrations and well-planned rollout strategies that account for limited institutional access and training opportunities. Early engagement with pharmacy teams and other institutional stakeholders was viewed as essential for approvals and integration into workflow. Training programs that emphasize the device's design and patient considerations, supported by cross-disciplinary collaboration, were highlighted as key to building confidence among clinical staff. Leveraging nurse-reported outcomes and educational success stories can further support peer confidence, while careful documentation of real-world experiences may inform future practice standards.

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