MDFORLIVES IN-DEPTH INSIGHT REPORT

Cellular Therapy in Practice: Where CAR-T and TIL Access Still Breaks Down

A peer insight report on referral timing, manufacturing delay, toxicity confidence, evidence gaps, community access and priorities for the next phase of CAR-T and TIL delivery.

Medical and Hematologic Oncologists · 6 countries · Global peer perspectives

50	64	6	78.1%
Complete responses	Survey records	Countries represented	Completion rate

THE CLINICAL QUESTION

If a patient is eligible for cellular therapy but the pathway cannot move fast enough, where does the clinical opportunity get lost?

The largest pressures sit before and around treatment rather than in a single toxicity concern. Respondents emphasize referral timing, real-world evidence, manufacturing and center-to-center workflow, with disease progression during the wait emerging as a major reason not to proceed.

The full report maps clinical urgency, evidence gaps, referral confidence, operational barriers and the priorities oncologists want the field to solve next.

Coverage: United States, United Kingdom, Canada, Italy, France, Germany. Survey ID: 8916068. Percentages are shown exactly as reported at each question base.

EXECUTIVE SUMMARY

The pattern in one view

The survey suggests that the next cellular-therapy problem is not simply inventing another product. It is making the pathway faster, earlier and more connected. Oncologists see the highest urgency in heavily pretreated patients, but those patients are also most vulnerable to referral and manufacturing delay. The strategic challenge is therefore to align scientific progress with operational progress so that a therapy's potential is not lost between eligibility, transfer, cell production and treatment.

01 / PATIENT URGENCY
54.9%
place relapsed or refractory patients after multiple prior lines at the highest urgency for better cellular options. The greatest urgency still sits with patients who have already exhausted substantial therapy.

02 / REFERRAL TIMING
29.4%
name optimal identification and referral timing as the greatest unmet clinical need. The pathway can fail before manufacturing begins if referral occurs after disease has accelerated.

03 / EVIDENCE
29.4%
want real-world effectiveness versus trial performance most urgently. Clinicians are asking how cellular therapies behave outside highly selected study environments.

04 / TOXICITY
76.5%
are at least moderately confident managing CRS and ICANS. Confidence is substantial but not universal, leaving a meaningful group who remain only slightly or not confident.

Reading across the findings: The largest pressures sit before and around treatment rather than in a single toxicity concern. Respondents emphasize referral timing, real-world evidence, manufacturing and center-to-center workflow, with disease progression during the wait emerging as a major reason not to proceed.

SECTION 01

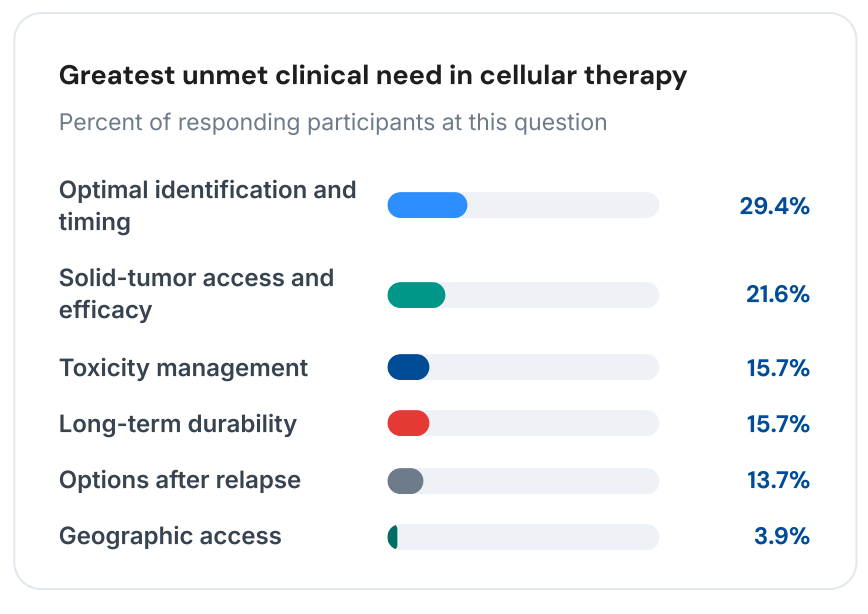
The greatest unmet need begins with timing the pathway correctly

CONTEXT
The greatest unmet need begins with timing the pathway correctly is one part of the wider operating pattern captured in this survey.

DATA
29.4% identify finding eligible patients at the optimal time before rapid progression as the greatest unmet need, followed by 21.6% who prioritize expanding access and efficacy in solid tumors. Toxicity management and long-term durability each receive 15.7%.

INSIGHT
The leading concern is not simply whether a cellular therapy exists. It is whether the right patient reaches the pathway early enough to benefit from it.

WHY IT MATTERS
Referral timing becomes clinically consequential when disease trajectory can outpace manufacturing, scheduling or transfer to a certified center.



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SECTION 02

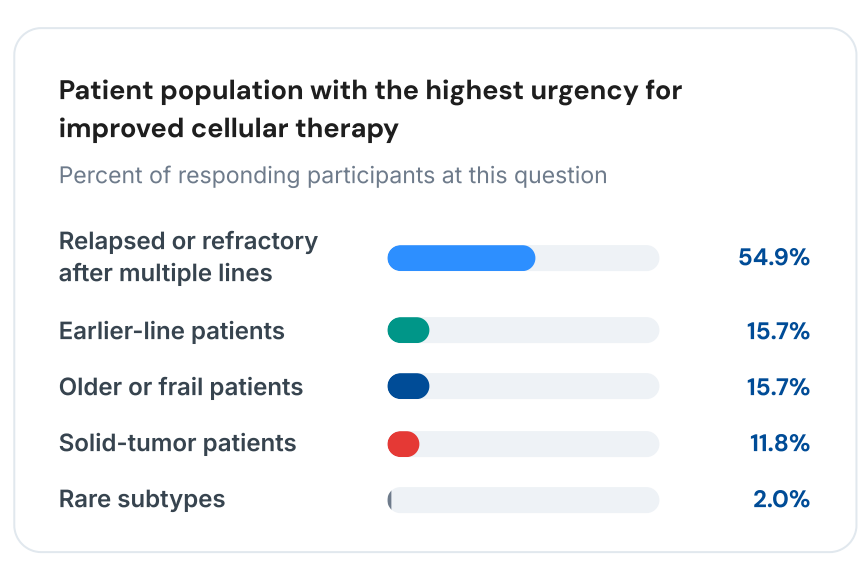
Relapsed and refractory patients remain the group with the highest perceived urgency

CONTEXT
Relapsed and refractory patients remain the group with the highest perceived urgency is one part of the wider operating pattern captured in this survey.

DATA
54.9% select heavily pretreated relapsed or refractory patients as the population with the highest urgency for improved cellular therapy options. Earlier-line patients and older or frail patients each receive 15.7%, solid-tumor patients 11.8%, and rare subtypes 2.0%.

INSIGHT
The field's expansion is important, but clinicians still see the sharpest immediate need in patients with few remaining alternatives.

WHY IT MATTERS
This creates a tension: the patients with the greatest urgency may also have the least time and physiologic reserve to navigate a slow pathway.



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SECTION 03

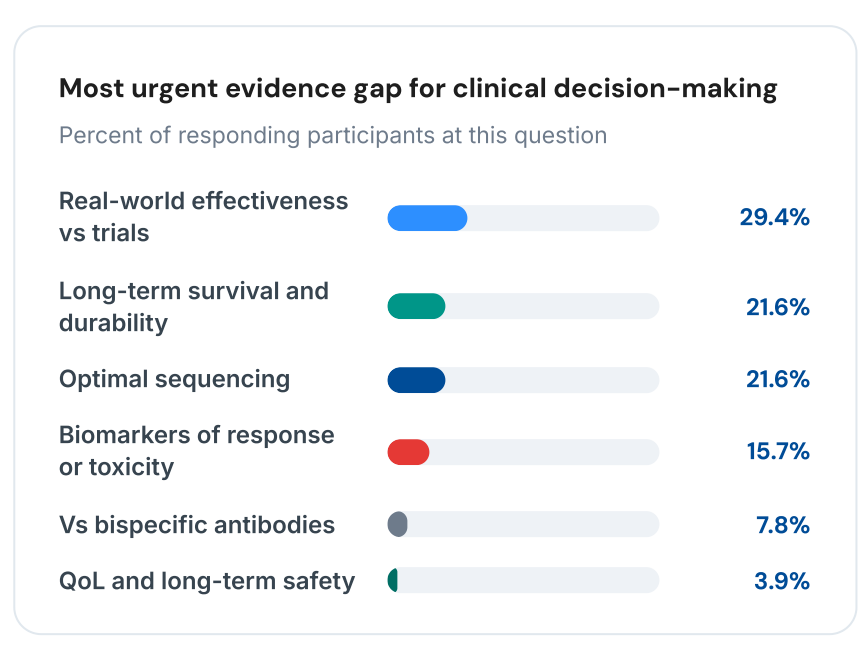
Real-world performance and treatment sequencing are the evidence questions closest to practice

CONTEXT
Real-world performance and treatment sequencing are the evidence questions closest to practice is one part of the wider operating pattern captured in this survey.

DATA
29.4% most urgently want evidence on real-world effectiveness versus trial performance. Long-term survival and durability and optimal sequencing each receive 21.6%, biomarkers 15.7%, comparative effectiveness versus bispecific antibodies 7.8%, and quality of life or long-term safety 3.9%.

INSIGHT
The dominant evidence questions are translational: how the therapy performs in routine patients and where it belongs relative to rapidly evolving alternatives.

WHY IT MATTERS
As treatment choices multiply, a therapy can be effective in isolation but still difficult to place without sequencing and comparative evidence.



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SECTION 04

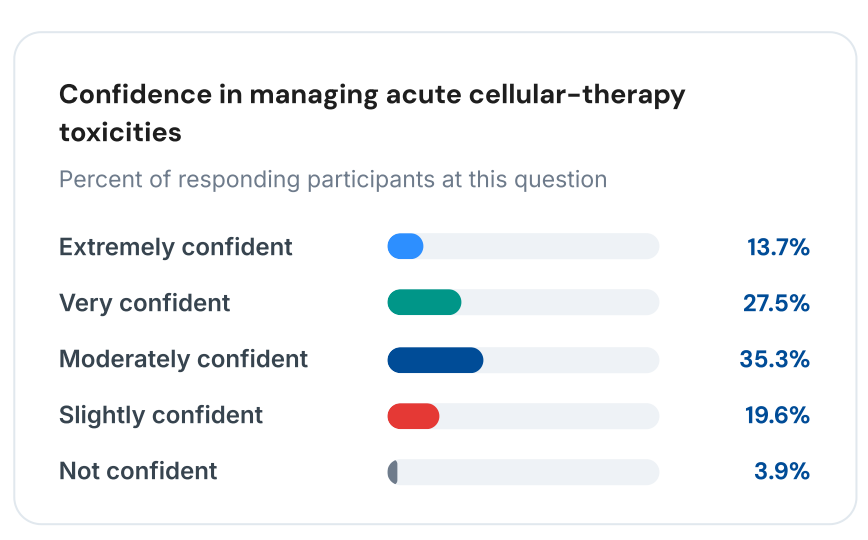
Clinician confidence is stronger for toxicity management than the pathway around referral

CONTEXT
Clinician confidence is stronger for toxicity management than the pathway around referral is one part of the wider operating pattern captured in this survey.

DATA
For CRS and ICANS, 13.7% are extremely confident, 27.5% very confident, 35.3% moderately confident, 19.6% slightly confident and 3.9% not confident. For referral timing, 92.2% are at least moderately confident.

INSIGHT
Knowledge confidence is not the same as pathway capacity. Many clinicians know when they would like to refer and feel able to manage common toxicities, yet access can still break down operationally.

WHY IT MATTERS
Education remains necessary, but additional education alone cannot solve transfer delays, manufacturing turnaround or patient travel constraints.



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SECTION 05

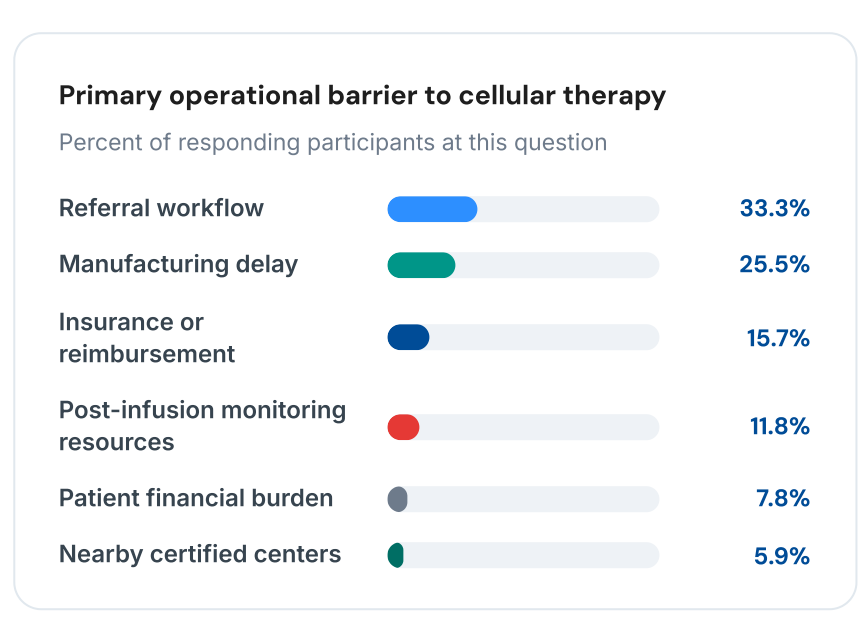
Referral workflow and manufacturing time are the two biggest operational bottlenecks

CONTEXT
Referral workflow and manufacturing time are the two biggest operational bottlenecks is one part of the wider operating pattern captured in this survey.

DATA
33.3% choose complex or slow referral workflows as the primary barrier, 25.5% choose manufacturing delay, 15.7% insurance or reimbursement, 11.8% intensive monitoring resources, 7.8% patient financial burden and 5.9% lack of nearby certified centers.

INSIGHT
The access chain is distributed across institutions. No single actor controls community referral, academic intake, manufacturing, payer approval, travel and post-infusion monitoring.

WHY IT MATTERS
Improving one step can simply move the queue to the next unless the pathway is redesigned end to end.



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SECTION 06

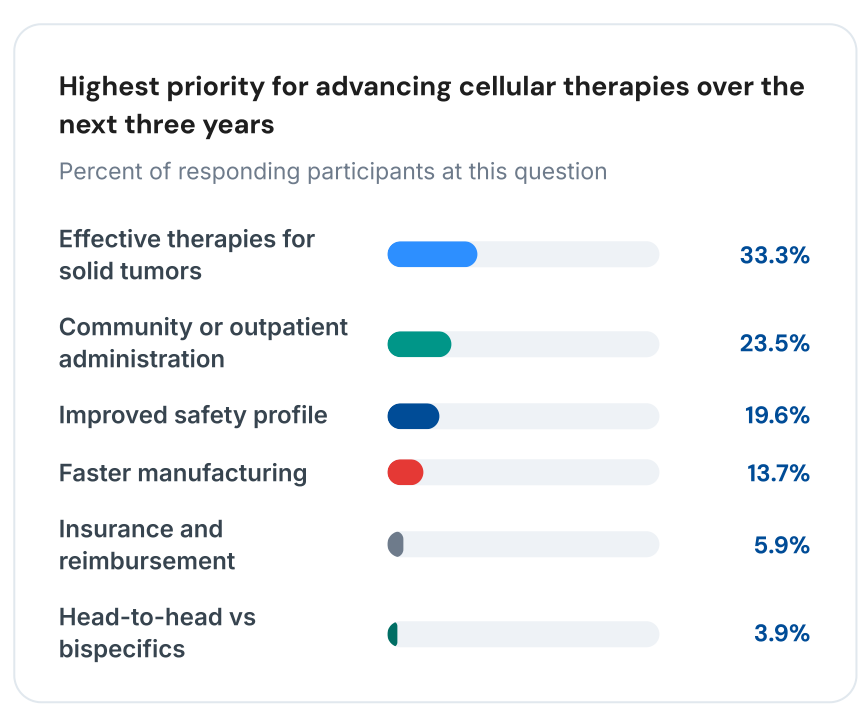
The next phase of cellular therapy is expected to expand both setting and disease reach

CONTEXT
The next phase of cellular therapy is expected to expand both setting and disease reach is one part of the wider operating pattern captured in this survey.

DATA
33.3% select effective cellular therapies for solid tumors as the highest three-year priority. 23.5% prioritize community or outpatient administration, 19.6% improved safety profiles, 13.7% faster manufacturing, 5.9% reimbursement, and 3.9% head-to-head evidence versus bispecific antibodies.

INSIGHT
The top priorities move in two directions: broaden what cellular therapy can treat and broaden where it can be delivered.

WHY IT MATTERS
Scientific expansion without delivery expansion can deepen access concentration, while decentralization without safety and manufacturing improvements can strain community capacity.



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PRACTICE PATTERN

What may be sitting underneath the responses

These are interpretive patterns, not clinical recommendations. They describe tensions that appear when the survey findings are read together.

01 / WORKFLOW
Clinical intent is only one part of delivery
The survey repeatedly shows that timing, access, coordination and administrative design shape whether a clinical decision can be carried through.

02 / EVIDENCE
Confidence depends on the evidence available at the moment of decision
Where evidence is incomplete, difficult to access or not well translated into workflow, clinicians create compensating behaviors such as escalation, workarounds or selective use.

03 / SYSTEMS
Specialty expertise cannot fully offset system friction
Many barriers sit outside the clinician's direct control, which means the next improvement often requires redesign around the specialist rather than more specialist effort.

CLOSING PERSPECTIVE

Cellular Therapy in Practice: Where CAR-T and TIL Access Still Breaks Down

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CONCEPT FAQ

Clinical questions about CAR-T, TIL and cellular therapy delivery

What is the difference between CAR-T therapy and TIL therapy?
Both are forms of adoptive T-cell therapy. CAR-T therapy collects a patient's T cells and genetically engineers them to recognize a selected target on cancer cells. TIL therapy collects T cells that have already entered a tumor, expands selected cells in the laboratory and returns large numbers of them to the patient.

Which cancers are currently treated with CAR-T or TIL therapy?
Approved CAR-T therapies are established mainly in selected hematologic malignancies such as certain leukemias, lymphomas and multiple myeloma. TIL therapy has an FDA-approved option, lifileucel, for certain adults with advanced melanoma after specified prior treatment. Research is continuing across additional solid tumors.

Why does referral timing matter for cellular therapy?
Cellular therapy is a multi-step pathway that can require specialist assessment, cell or tumor collection, manufacturing or expansion, testing, conditioning therapy and coordinated infusion. Patients with rapidly progressing disease can lose clinical fitness or eligibility while those steps are being organized, so early referral can preserve options.

What are CRS and ICANS?
Cytokine release syndrome (CRS) is a systemic inflammatory reaction that can occur after CAR-T-cell activation. Immune effector cell-associated neurotoxicity syndrome (ICANS) is a neurologic toxicity that can also occur after treatment. Both can be severe and require structured monitoring and treatment protocols.

Why is manufacturing a central part of autologous cellular therapy?
For autologous products, the therapy is made from an individual patient's cells. Collection, transport, manufacturing or expansion, quality testing, release and return to the treatment center create a patient-specific supply chain in which timing, chain-of-identity and coordination are clinically important.

Why has cellular therapy been harder to translate to many solid tumors?
Solid tumors create additional biological barriers, including heterogeneous targets, difficulty getting T cells into the tumor, immunosuppressive signals in the tumor microenvironment and T-cell dysfunction or exhaustion. TIL therapy in melanoma shows that cellular therapy can work in a solid tumor, while broader use remains an active research area.

Clinical context sources: National Cancer Institute: T-cell Transfer Therapy · National Cancer Institute: CAR T Cells · National Cancer Institute: Lifileucel · FDA prescribing information: CAR-T safety monitoring example. These FAQs provide general educational context and do not replace specialty guidance or patient-specific clinical judgment.

SELECTED EXTERNAL CONTEXT

- National Cancer Institute, T-cell Transfer Therapy
- National Cancer Institute, Lifileucel First Cellular Therapy Approved for Cancer
- National Cancer Institute, Lifileucel

Source note: External references provide clinical and regulatory context. All survey percentages and response counts come from the MDForLives survey export identified above.

Visual Graphs and Backend Data

Percentages and counts are reproduced from MDForLives survey SGID 8916068. Question bases vary across partial completes.

Survey profile

Metric	Value
Completion rate	78.1%
Complete	50
Partial	14
Total survey records	64
Countries	United States, United Kingdom, Canada, Italy, France, Germany

Section 01: Greatest unmet clinical need in cellular therapy

Response option	Percent	Responses
Optimal identification and timing	29.4%	15
Solid-tumor access and efficacy	21.6%	11
Toxicity management	15.7%	8
Long-term durability	15.7%	8
Options after relapse	13.7%	7
Geographic access	3.9%	2

Section 02: Patient population with the highest urgency for improved cellular therapy

Response option	Percent	Responses
Relapsed or refractory after multiple lines	54.9%	28
Earlier-line patients	15.7%	8
Older or frail patients	15.7%	8
Solid-tumor patients	11.8%	6
Rare subtypes	2.0%	1

Section 03: Most urgent evidence gap for clinical decision-making

Response option	Percent	Responses
Real-world effectiveness vs trials	29.4%	15
Long-term survival and durability	21.6%	11
Optimal sequencing	21.6%	11
Biomarkers of response or toxicity	15.7%	8
Vs bispecific antibodies	7.8%	4
QoL and long-term safety	3.9%	2

Section 04: Confidence in managing acute cellular-therapy toxicities

Response option	Percent	Responses
Extremely confident	13.7%	7
Very confident	27.5%	14
Moderately confident	35.3%	18
Slightly confident	19.6%	10
Not confident	3.9%	2

Section 05: Primary operational barrier to cellular therapy

Response option	Percent	Responses
Referral workflow	33.3%	17
Manufacturing delay	25.5%	13
Insurance or reimbursement	15.7%	8
Post-infusion monitoring resources	11.8%	6
Patient financial burden	7.8%	4
Nearby certified centers	5.9%	3

Section 06: Highest priority for advancing cellular therapies over the next three years

Response option	Percent	Responses
Effective therapies for solid tumors	33.3%	17
Community or outpatient administration	23.5%	12
Improved safety profile	19.6%	10
Faster manufacturing	13.7%	7
Insurance and reimbursement	5.9%	3
Head-to-head vs bispecifics	3.9%	2