CRA Insights

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CAR-T vs bispecifics: Utilization patterns and insights in hematologic oncology

In this analysis, we seek to assess how the utilization of CAR-T and bispecific therapies has evolved over the last few years. Which modality is winning with organized customers,[1] and what is driving adoption? Is the promise of CAR-Ts' superior efficacy enough to outweigh its logistical and administrative burden, or is the bispecific value proposition of comparable efficacy with easier administration driving greater relative utilization? Most importantly, we ask: Has utilization of these therapies spread beyond academic medical centers? Or do these products remain concentrated within that limited footprint?

Introduction/background

Both CAR-T and bispecific treatment options are transformative therapies in hematology-oncology and have recently experienced significant growth in provider acceptance and utilization in the US.

While CAR-T represents a potentially curative option for some patients, the administrative, logistical, and tolerability challenges are often a barrier to broader adoption. By contrast, bispecific T-cell engagers have demonstrated significant clinical benefit, though with markedly less tolerability and safety challenges. For example, in 2L and 3L large B-cell lymphoma (LBCL), CAR-Ts can achieve complete response rates up to 70%-80% (e.g., 74% for Breyanzi in the TRANSFORM trial[2]), while for bispecific antibodies, complete response rates are generally in the 40%-50% range (e.g., 47% for Epcoritamab in the EPCORE NHL-6 trial[3]).

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1 Throughout this analysis, we use the term 'organized customers' and 'healthcare organizations (HCOs)' interchangeably to refer collectively to academic medical centers, provider groups, and integrated delivery networks (IDNs)—essentially the institutional-level decision-makers that determine which therapies are brought into their networks.

2 Abramson J, Solomon S, Arnason J, et al. Lisocabtagene maraleucel as second-line therapy for large B-cell lymphoma: primary analysis of the phase 3 TRANSFORM study. Blood. 2023;141(14):1675-1684.

3 https://ir.genmab.com/news-releases/news-release-details/genmab-announces-updated-results-phase-2-epcorer-nhl-6-study/.

Similarly, from a safety perspective, CAR-T is associated with higher rates of severe (Grade 3+) adverse events, including cytokine release syndrome (CRS, ~7%-10%) and immune effector cell-associated neurotoxicity syndrome (ICANS, ~10%-15%)[4], compared with generally lower rates of high-grade CRS (~2%) and rare ICANS (~1%)[5] for bispecifics.[6] These differences have been substantiated across trials and meta-analyses.[7]

Given this background, we sought to understand whether CAR-T and bispecific utilization has spread beyond academic medical centers, and where the growth in utilization for each therapy class is coming from. Specifically:

a) Has the constellation of institutions using CAR-T and bispecifics diversified beyond the handful of accounts with significant clinical experience, or does utilization remain concentrated?

b) Is CAR-Ts' superior efficacy enough to drive continued adoption despite meaningful logistical and administrative barriers, or is the bispecific value proposition of strong efficacy with easier administration winning out among organized customers?

CAR-T vs Bispecific implementation (organized customers)

Building on these questions on sources of growth and breadth of adoption for CAR-Ts and bispecifics, we examined the practical and operational factors that organized customers evaluate when determining which treatment options to integrate into their practice.

Category	Factor	CAR-Ts	Bispecifics
Clinical factors	Efficacy	↑ High response rates; potential for durable remission / cure	↑ Strong efficacy but generally less durable than CAR-T
	Safety / tolerability	↓ Higher rates of severe CRS / ICANS, requiring specialized monitoring	↑ Lower rates of severe CRS / ICANS and more manageable toxicity
	Indications	↑ FDA-approved across multiple hematologic malignancies with continued expansion across lines of therapy	↑ FDA-approved across multiple hematologic malignancies; expanding rapidly, particularly in later-line settings

4 Sesques P, et al. Real-world outcomes of anti-CD19 CAR-T cell therapy for large B-cell lymphoma: results from the French DESCAR-T registry. Journal of Hematology & Oncology. 2024;17:61.

5 Shumilov E, et al. Glofitamab treatment in relapsed or refractory large B-cell lymphoma: real-world experience. Blood Advances. 2025;9(15):3865–3877.

6 Abbreviations: CRS = Cytokine Release Syndrome; ICANS = Immune Effector Cell-Associated Neurotoxicity Syndrome.

7 Kim, J., at al. CAT T cells vs bispecific antibody as third-or later-line large B-cell lymphoma therapy: a meta-analysis. Blood. 2024; 144:6.

Patient factors	Post-infusion monitoring requirement	↓ Real-world access is constrained due to post-infusion observation period of two weeks, despite elimination of FDA REMS requirements in June 2025	↑ Post-infusion observation period of 48 hours; no REMS requirements
	Manufacturing / time to treatment	↓ Improving manufacturing turnaround times, but still weeks from referral to infusion	↑ Off-the-shelf availability enables rapid treatment initiation
	Referral pathway complexity	↓ Requires coordination and clear communication across referring practices	↑ Fewer cross-institutional handoffs; typically administered within a single treating practice
Infrastructural and financial factors	Foundation for the Accreditation of Cellular Therapy (FACT) accreditation requirements	↓ Required for administration	↑ Not required
	Financial investment	↓ High upfront institutional investment, with reimbursement later	↑ Lower upfront investment with more predictable reimbursement
	Infrastructure / workflows (onboarding)	↓[8] Requires apheresis units, cell processing logistics, inpatient capability, and intensive monitoring to manage CRS/ICANS	↑ No apheresis needed; outpatient-friendly, though patient support still necessary

↑ = Driver ↓ = Barrier

Taken together, these comparisons highlight the trade-offs that organized customers navigate, motivating a closer examination of how these factors influence real-world adoption behaviors.

Approach and methodology

To investigate this question, we analyzed a sample of 25% of Komodo claims, for the following CAR-T and bispecific antibody products from 2021 through 2025:

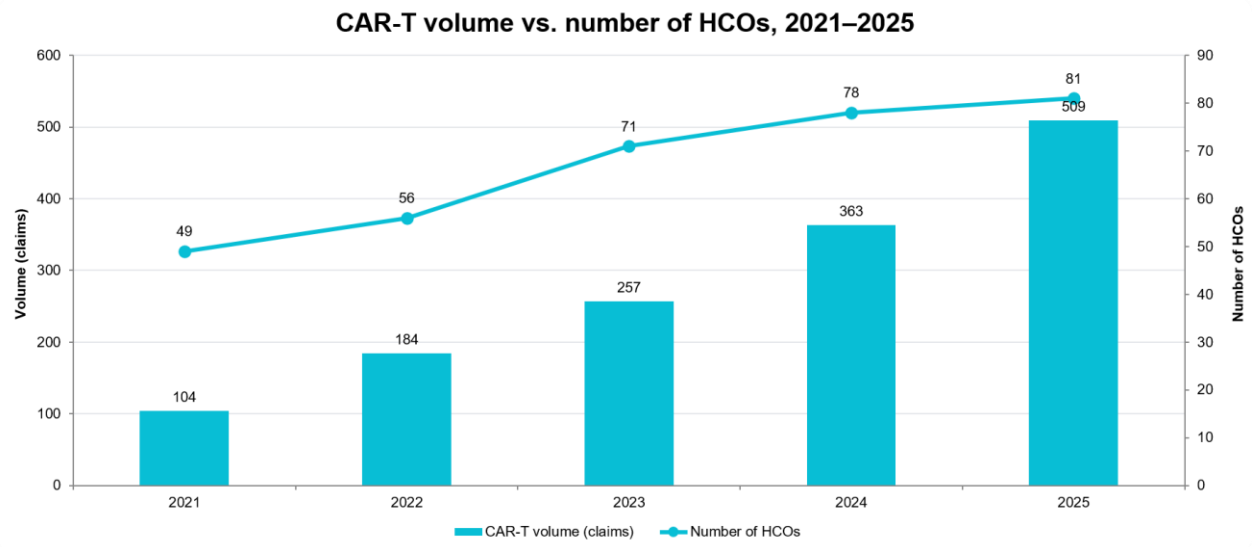
CAR-Ts	Abecma, Aucatzyl, Breyanzi, Carvykti, Kymriah, Tecartus, Yescarta
Bispecific antibodies	Columvi, Elrexfio, Epkinly, Lunsumio, Lynozyfic, Tecvayli

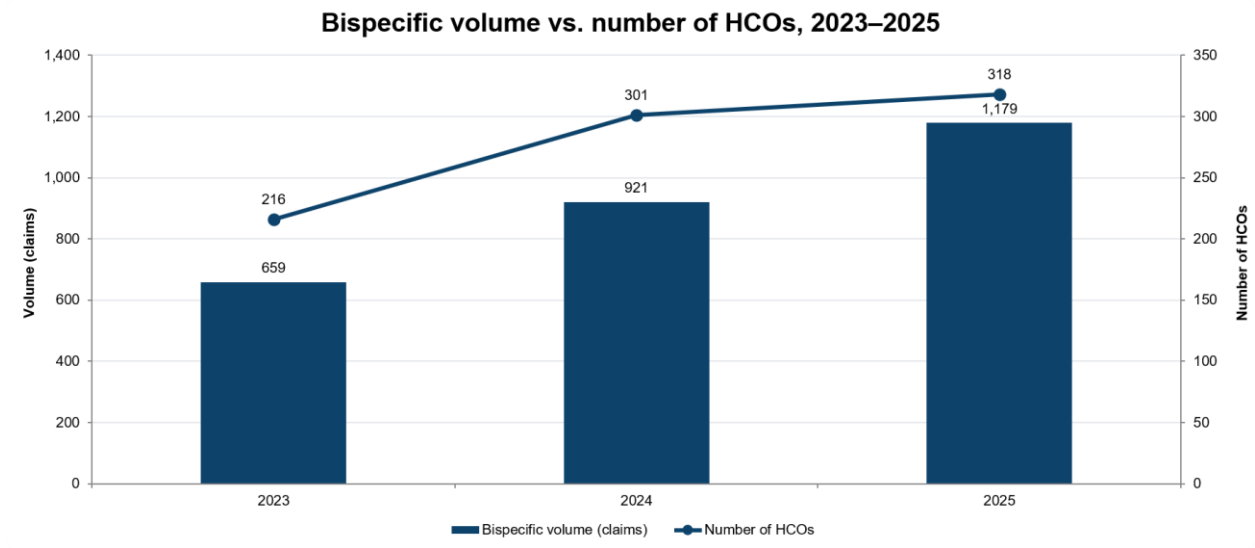
Note on methodology: This analysis is based on Komodo Health's patient-level claims database, with full medical (Mx) and pharmacy (Rx) claims, spanning January 2021-2025.

[8] However, next-generation allogeneic ("off-the-shelf") CAR-T approaches may reduce reliance on apheresis and simplify logistics over time.

Results

Volume has grown substantially for both CAR-T and bispecific therapies since they entered the market, but growth alone does not tell us whether that volume is reaching new organized customers. At the surface, both CAR-T and bispecific products have seen a significant increase in overall claims, and the total number of organized customers with at least one claim has increased for both the set of CAR-T products and the set of bispecific products [see following graphs].

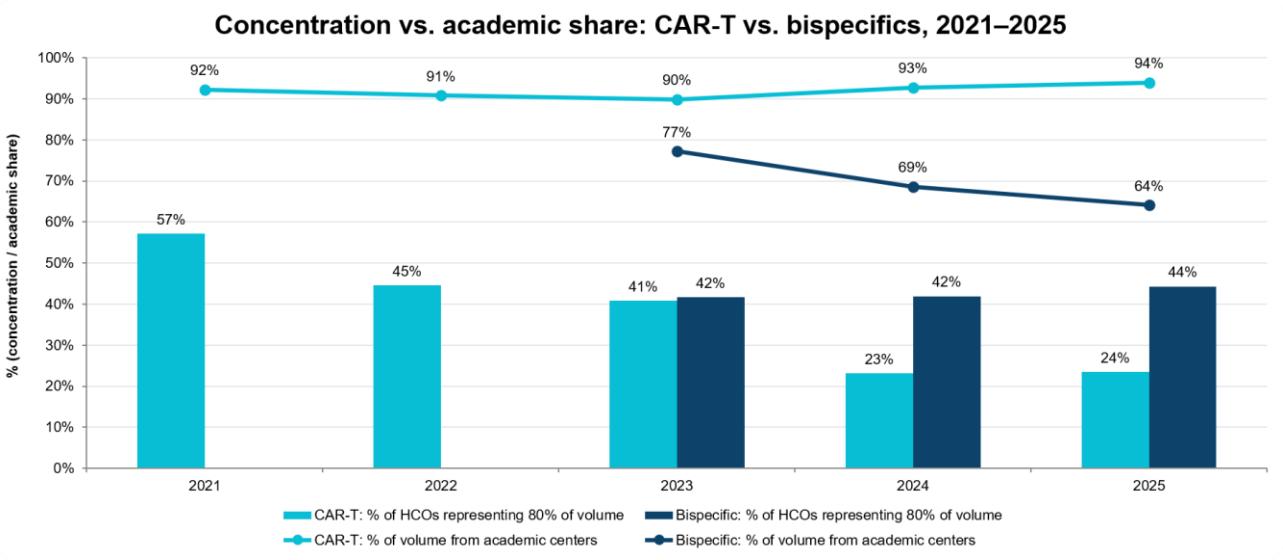




CAR-T trends and discussion

Looking at the number of HCOs administering each therapy tells a similar growth story. However, the growth rate of HCOs administering CAR-T is much lower than the nearly 5x volume growth in CAR-T, indicating that a largely fixed set of institutions is absorbing most of the increase. Bispecific HCO count, on the other hand, has grown in line with volume (216 to 318, +47% vs +79% volume growth) since 2023, consistent with an expanding base of prescribing institutions.

With this in mind, the real question is whether **CAR-T utilization has spread beyond academic medical centers**. As the data below show, the answer is a resounding "no." CAR-T's share of volume coming from academic centers has stayed remarkably stable, from 92% in 2021 to 94% in 2025. We also consider the concentration of utilization: measured by the number of HCOs needed to reach 80% of the utilization in a year. When the first CAR-T launched in 2021, utilization was fairly diffuse: more than half of HCOs accounted for 80% of the volume in 2021. In the ensuing years, while CAR-T volume has expanded nearly 5x, utilization has become **more concentrated**: 23% of HCOs accounted for 80% of CAR-T utilization in 2025. Even as overall CAR-T volume climbs, that growth is being absorbed by a shrinking universe of health systems. In fact, in our sample of data, **the top 10 organizations represent 69% of CAR-T utilization**.



Bispecific utilization trends

The story for the bispecific class is, in many ways, the opposite. The share of bispecific volume from academic medical centers has fallen from 77% in 2023 to 64% in 2025. And the number of HCOs required to reach 80% of volume has actually increased: 44% of HCOs now account for 80% of bispecific utilization in 2025, up from 42% in 2023. This indicates that the constellation of centers using bispecifics is broadening, even as overall volume increases. Indeed, this trend is reinforced by the fact that the **top 10 HCOs only accounted for 23% of volume in 2025**, representing a downward trend from 27% in 2023.

Discussion

The divergent growth pattern between CAR-Ts and bispecifics shows that concentration and academic reliance are moving in opposite directions for the two therapy classes. CAR-T volume growth is being absorbed by a largely static group of HCOs, and utilization is intensifying within a small set of institutions that remains overwhelmingly academic (94% of volume in 2025). In contrast, bispecific utilization is diffusing into a growing, community-based set of accounts, which is reflected by the falling academic share from 77% in 2023 to 64% in 2025.

Conclusion

What happens next and what does it mean for the market?

With CAR-T utilization concentrated in a small and largely static set of academic health systems, expansion beyond the current academic footprint should be a primary strategic priority for CAR-T manufacturers. Leading academic centers will continue to use CAR-T and are likely to remain a stable part of the CAR-T business. However, with new innovations (additional CAR-T products, trispecifics) this portion of the business is likely to become increasingly competitive and unstable. If current trends continue, CAR-T manufacturers may find themselves trying to win in a smaller share of a shrinking pie.

CAR-T manufacturers have a challenging choice to make:

a) **Win in the academic setting.** Continue to compete for share within an increasingly saturated market and likely narrow the clinical story to a smaller set of patients that they can defend against new innovations. This strategy relies on hyper-targeting and a strong clinical story, but is likely not a viable long-term strategy.

b) **Expand the market.** Expand the base of treating institutions.

Both options entail risks and differentiated capabilities. Winning in the academic setting will require carving out a place for uncontested clinical differentiation through evidence generation, KOL engagement, and strong partnerships with this small universe of HCOs. Differentiation may require being the “best CAR-T” for a specific patient population and will likely include operational, logistical and account-specific capabilities.

Expanding the market is also a significant challenge. Here, manufacturers need to characterize the universe of health systems and identify the unique barriers to adoption for each account which they can address (e.g., logistical, financial, tolerability/safety). Those who are successful will find a way to simplify referral pathways, reduce infrastructure burden, support strong market access and reimbursement, and expand into earlier lines of therapy, thereby improving the financial rationale of an investment in CAR-T onboarding. The focus of this strategy is in building a reproducible capability in account onboarding and rapid problem-solving to remove barriers to onboarding and operationalization – taking a broad approach to market development and expansion. This is opposed to the more focused, deepening of relationships and patient niching required to win in the academic setting.

For bispecific manufacturers, by contrast, the increasing expansion of utilization indicates that their strategy of expanding beyond academic medical centers is working. To continue this momentum of community HCO penetration, the most successful will build a differentiated capability in new account onboarding, and bring on new accounts faster than their competitors, thereby continuing their broad market penetration.

Further, bispecific manufacturers need to focus on maintaining a value proposition advantage over CAR-T’s: highlighting the strong efficacy profile, continuing to manage the adverse-event profile, and ensuring consistent coverage and reimbursement. These products need to make the promise of an “off-the-shelf” option real and believable.

Overall, success in the market will require a range of capabilities from both CAR-T and bispecific manufacturers:

- **Organized customer segmentation** to characterize the market and patient opportunity, identify the right targets for expansion, and build tailored strategies for engagement.
- **HCO implementation toolkits** to effectively onboard new accounts to the CAR-T manufacturing and treatment process or the bispecific patient monitoring protocol.
- **Market access expertise** to address potential payer challenges, secure favorable payer reimbursement, and offer innovative payment mechanisms to HCOs for CAR-T therapies – particularly for non-academic accounts with greater financial sensitivity.
- **Value demonstration and evidence generation** to build on the clinical evidence for utilization of these innovative products; claim a clear place in therapy for the evolving treatment paradigms of Multiple Myeloma and non-Hodgkin lymphomas among others; and provide clinical differentiation for specific patient populations.

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Contacts

Chris Nüesch
Vice President
+1-202-662-7865
cnuesch@crai.com

CRA Charles River Associates