Teclistamab Monotherapy

INDICATIONS FOR USE:

INDICATION	ICD10	Regimen Code	HSE approved reimbursement status*
As monotherapy for the treatment of adult patients with relapsed and refractory multiple myeloma, who have received at least three prior therapies, including an immunomodulatory agent, a proteasome inhibitor and an anti-CD38 antibody and have demonstrated disease progression on the last therapy.	C90	00865a	ODMS 01/03/2025

* This applies to post 2012 indications

TREATMENT:

The starting dose of the drugs detailed below may be adjusted downward by the prescribing clinician, using their independent medical judgement, to consider each patients individual clinical circumstances.

Teclistamab is administered at a dose of 1.5mg/kg by subcutaneous (SC) injection **ONCE WEEKLY** every 28 days, preceded by step-up doses of 0.06 mg/kg and 0.3 mg/kg in cycle 1, to reduce the risk of cytokine release syndrome (CRS).

For patients who have a complete response or better for a minimum of 6 months, consideration can be given to reducing the dosing frequency to 1.5mg/kg SC every **TWO** weeks **(See NCCP regimen 00927 Teclistamab Monotherapy – Two Weekly Maintenance)**. Consideration may also be given to **MONTHLY** dosing at the discretion of the prescribing Consultant, noting that this would be an unlicensed dosing posology.

The recommended dosing schedule (including dose titration) is shown in tables 1 and 2 below. Treatment should be continued until disease progression or unacceptable toxicity occurs.

Due to the risk of cytokine release syndrome (CRS) treatment should be initiated in the inpatient setting. All patients must be monitored for signs and symptoms of CRS daily for 48 hours after administration of all doses within the step-up dosing schedule, and those who have previously experienced a grade 2 or higher CRS.

In the event of CRS and/or Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS), tocilizumab[i] and emergency equipment must be available for each patient. The treatment centre must have access to additional doses of tocilizumab[i] within 8 hours.

Facilities to treat anaphylaxis MUST be present when systemic anti-cancer therapy (SACT) is administered.

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Table 1: Cycle 1 treatment schedule

Drug	Day	Description	Dose	Route	Cycle
Teclistamab[a, b]	1	Step-up dose 1	0.06 mg/kg	[e]SC (abdomen or thigh)	C1 only
	3[c]	Step-up dose 2	0.3 mg/kg	[e]SC (abdomen or thigh)	
	5[d]	First maintenance dose	1.5 mg/kg	[e]SC (abdomen or thigh)	
[a] Dose is based on actual body weight					
[b] See Table 3 for recommendations on restarting teclistamab after dose delays.					
[c] Step-up dose 2 may be given between two to seven days after Step-up dose 1.					
[d] First maintenance dose may be given between two to seven days after Step-up dose 2. This is the first full maintenance dose (1.5 mg/kg).					
[e] Injection volume should not exceed 2mL. Doses requiring greater than 2mL should be divided equally into multiple syringes and injected at sites at least 2cm apart.					

Table 2: Treatment schedule for Cycle 2 onwards (to start 7 days after first maintenance dose)

Drug	Day	Dose	Route	Cycle
Teclistamab[a b]	1, 8, 15, 22[c]	1.5 mg/kg[d]	[e]SC (abdomen or thigh)	Every 28 days from cycle 2 onwards.
[a] Dose is based on actual body weight.				
[b] See Table 3 for recommendations on restarting teclistamab after dose delays.				
[c] For patients who have a complete response or better for a minimum of 6 months, consider reducing the dosing frequency to 1.5mg/kg S.C. every **two** weeks **(See NCCP regimen 00927 Teclistamab Monotherapy – Two Weekly Maintenance)**. Consideration may also be given to **monthly** dosing at the discretion of the prescribing Consultant, noting that this would be an unlicensed dosing posology.				
[d] Maintain a minimum of five days between weekly maintenance doses.				
[e] Injection volume should not exceed 2mL. Doses requiring greater than 2mL should be divided equally into multiple syringes and injected at sites at least 2cm apart.				

ELIGIBILITY:

- Indication as above
- ECOG 0-1

EXCLUSIONS:

- Hypersensitivity to teclistamab or any of the excipients
- Pregnancy
- Breastfeeding

PRESCRIPTIVE AUTHORITY:

The treatment plan must be initiated by a Consultant Haematologist working in the area of haematological malignancies

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TESTS:

Baseline tests:

- FBC, renal, liver and bone profile, blood glucose
- Serum LDH
- Serum protein electrophoresis (SPEP) to assess disease response in terms of paraprotein and also quantitative immunoglobulins i.e. total IgG, as clinically indicated
- Virology screen* - Hepatitis B virus (HBV) serology [HBV sAg, HBV sAb, HBV cAb], hepatitis C virus (HCV) serology

  *(See Regimen Specific Complications for information on Hepatitis B reactivation)

Regular tests:

- FBC, renal, liver profile, serum LDH, blood glucose
  - Cycle 1: prior each dose
  - Cycle 2: prior to dose on cycle 2 day 1, with optional testing prior to each dose on days 8, 15 and 22.
  - Cycle 3 onwards prior to dose on day 1
- SPEP to assess disease response in terms of paraprotein and also quantitative immunoglobulins i.e. total IgG, as clinically indicated
- Blood pressure
- Patients should continue to be monitored for signs and symptoms of CRS and ICANS (refer to Tables 6, 7 and 8 for management of CRS and ICANS)*
  ***See Regimen Specific Complications**

Disease monitoring:

Disease monitoring should be in line with the patient's treatment plan and any other test/s as directed by the supervising Consultant

DOSE MODIFICATIONS:

- Dose reductions of teclistamab are not recommended
- Dose delays may be required to manage toxicities related to teclistamab. Recommendations for restarting treatment after a dose delay are outlined in table 3
- Any dose modification should be discussed with a Consultant

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Table 3: Recommendations for restarting therapy with teclistamab after dose delay

Last dose administered	Duration of delay from the last dose administered	Action
Step-up dose 1	> 7 days	Restart step-up dosing schedule at Step-up dose 1 (0.06 mg/kg)[a].
Step-up dose 2	8 days – 28 days	Repeat Step-up dose 2 (0.3 mg/kg)[a] and continue step-up dosing schedule.
	> 28 days	Restart step-up dosing schedule at Step-up dose 1 (0.06 mg/kg)[a].
Any maintenance doses	8 days – 62 days	Continue at last maintenance dose and schedule (1.5mg/mg once weekly or 1.5mg/kg every two weeks)
	63 days-111 days	Restart step-up dosing schedule at Step-up dose 2 (0.3 mg/kg)[a].
	> 111 days	Restart step-up dosing schedule at Step-up dose 1 (0.06 mg/kg)[a].

[a] Pre-treatment medicinal products (table 9) should be administered prior to teclistamab dose and patients monitored accordingly.

Haematological:

Table 4: Dose modification in haematological toxicity

Haematologic toxicity	Recommended action
Absolute neutrophil count less than $0.5x10^9$/L	Withhold teclistamab until absolute neutrophil count is $0.5x10^9$/L or higher.
Febrile neutropenia	Withhold teclistamab until absolute neutrophil count is $1.0x10^9$/L or higher, and fever resolves.
Platelet count less than $25x10^9$/L Platelet count between $25x10^9$/L and $50x10^9$/L with bleeding	Withhold teclistamab until platelet count is $25x10^9$/L or higher and no evidence of bleeding.
Haemoglobin less than 8 g/dL	Withhold teclistamab until haemoglobin is 8 g/dL or higher.

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Renal and Hepatic Impairment:

Table 5: Dose modification in renal and hepatic impairment

Renal Impairment	Hepatic Impairment
No dosage adjustment is recommended for patients with mild or moderate renal impairment. Limited data are available from patients with severe renal impairment.	No dosage adjustment is recommended for patients with mild hepatic impairment. No data are available in patients with moderate and severe hepatic impairment.
Renal and hepatic: Teclistamab SmPC	

Management of adverse events:

Table 6: Recommended actions taken after adverse events following administration of teclistamab

Adverse reactions	Grade	Actions
Cytokine release syndrome (CRS)[a]	Grade 1 • Temperature ≥38°C [b]	Withhold teclistamab until adverse reaction resolves. • See Table 7 for management of cytokine release syndrome. • Administer pre-treatment medicinal products prior to next dose of teclistamab.
	Grade 2 • Temperature ≥38°C [b] with either: ○ Hypotension responsive to fluids and not requiring vasopressors, or ○ Oxygen requirement of low-flow nasal cannula[c] or blow-by Grade 3 (Duration: less than 48 hours) • Temperature ≥38°C [b] with either: ○ Hypotension requiring one vasopressor with or without vasopressin, or ○ Oxygen requirement of high-flow nasal cannula[c], facemask, non-rebreather mask, or Venturi mask	• Withhold teclistamab until adverse reaction resolves. • See Table 7 for management of cytokine release syndrome. • Administer pre-treatment medicinal products prior to next dose of teclistamab. • Monitor patient daily for 48 hours following the next dose of teclistamab. Instruct patients to remain within proximity of a healthcare facility during daily monitoring.

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	Grade 3 (Recurrent or duration: more than 48 hours)
	• Temperature ≥38°C [b] with either:
	  ○ Hypotension requiring one vasopressor with or without vasopressin, or
	  ○ Oxygen requirement of high-flow nasal cannula[c], facemask, non-rebreather mask, or Venturi mask.
	
	Grade 4
	• Temperature ≥38°C [b] with either:
	  ○ Hypotension requiring multiple vasopressors (excluding vasopressin), or
	  ○ Oxygen requirement of positive pressure (e.g., continuous positive airway pressure [CPAP], bilevel positive airway pressure [BiPAP], intubation, and mechanical ventilation).
		• Permanently discontinue therapy with teclistamab.
		• See Table 7 for management of cytokine release syndrome.

Immune effector cell-associated neurotoxicity syndrome (ICANS)[d]	Grade 1	• Withhold teclistamab until adverse reaction resolves. • See Table 8 for management of immune effector cell-associated neurotoxicity syndrome.
	Grade 2 Grade 3 (First occurrence)	• Withhold teclistamab until adverse reaction resolves. • See Table 8 for management of immune effector cell-associated neurotoxicity syndrome. • Monitor patient daily for 48 hours following the next dose of teclistamab. Instruct patients to remain within proximity of a healthcare facility during daily monitoring.
	Grade 3 (Recurrent) Grade 4	• Permanently discontinue therapy with teclistamab. • See Table 8 for management of immune effector cell-associated neurotoxicity syndrome.

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Infections	All Grades	• Do not administer teclistamab step-up dosing schedule in patients with active infection. Teclistamab step-up dosing schedule may proceed upon resolution of active infection.
	Grade 3 Grade 4	• Withhold subsequent maintenance doses of teclistamab (i.e., doses administered after teclistamab step-up dosing schedule) until infection improves to Grade 2 or better.
Other adverse reactions[e]	Grade 3 Grade 4	• Withhold teclistamab until adverse reaction improves to Grade 2 or better.

[a] Based on American Society for Transplantation and Cellular Therapy (ASTCT) grading for CRS (Lee et al 2019).
[b] Attributed to CRS. Fever may not always be present concurrently with hypotension or hypoxia as it may be masked by interventions such as antipyretics or anticytokine therapy (e.g., tocilizumab[i] or corticosteroids).
[c] Low-flow nasal cannula is ≤6 L/min, and high-flow nasal cannula is >6 L/min.
[d] Based on ASTCT grading for ICANS.
[e] Based on National Cancer Institute Common Terminology Criteria for Adverse Events (NCI-CTCAE), Version 4.03.

Table 7: Recommendations for management of CRS with tocilizumab[i] and corticosteroids

Grade[a]	Presenting symptoms	Tocilizumab[b, i]	Corticosteroids[c]
Grade1	Temperature ≥38 °C[d]	May be considered	Not applicable
Grade 2	Temperature ≥38 °C[d] with either: • Hypotension responsive to fluids and not requiring vasopressors, or • Oxygen requirement of low-flow nasal cannula[e] or blow-by	Administer tocilizumab[c, i] 8 mg/kg intravenously over 1 hour (not to exceed 800 mg). Repeat tocilizumab[i] every 8 hours as needed, if not responsive to intravenous fluids or increasing supplemental oxygen. Limit to a maximum of 3 doses in a 24-hour period; maximum total of 4 doses.	If no improvement within 24 hours of starting tocilizumab[i], administer methylprednisolone 1 mg/kg intravenously twice daily, or dexAMETHasone 10 mg intravenously every 6 hours. Continue corticosteroid use until the event is Grade 1 or less, then taper over 3 days.
Grade 3	Temperature ≥38 °C[d] with either: • Hypotension requiring one vasopressor with or without vasopressin, or • Oxygen requirement of high-flow nasal cannula[e], facemask, non-rebreather mask, or Venturi mask	Administer tocilizumab[i] 8mg/kg intravenously over 1 hour (not to exceed 800 mg). Repeat tocilizumab[i] every 8 hours as needed, if not responsive to intravenous fluids or increasing supplemental oxygen. Limit to a maximum of 3 doses in a 24-hour period; maximum total of 4 doses.	If no improvement, administer Methylprednisolone 1 mg/kg intravenously twice daily, or dexAMETHasone 10 mg intravenously every 6 hours. Continue corticosteroid use until the event is Grade 1 or less, then taper over 3 days.

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Grade 4	Temperature ≥38 °C[d] with either: • Hypotension requiring multiple vasopressors (excluding vasopressin), or • Oxygen requirement of positive pressure (e.g., continuous positive airway pressure [CPAP], bilevel positive airway pressure [BiPAP], intubation, and mechanical ventilation)	Administer tocilizumab[i] 8 mg/kg intravenously over 1 hour (not to exceed 800 mg). Repeat tocilizumab[i] every 8 hours as needed if not responsive to intravenous fluids or increasing supplemental oxygen. Limit to a maximum of 3 doses in a 24-hour period; maximum total of 4 doses.	As above, or administer Methylprednisolone 1000 mg intravenously per day for 3 days, per physician discretion. If no improvement or if condition worsens, consider alternate immunosuppressants[c].

[a] Based on ASTCT grading for CRS (Lee et al 2019).
[b] Refer to tocilizumab[i] prescribing information for details.
[c] Treat unresponsive CRS per institutional guidelines.
[d] Attributed to CRS. Fever may not always be present concurrently with hypotension or hypoxia as it may be masked by interventions such as antipyretics or anticytokine therapy (e.g., tocilizumab[i] or corticosteroids).
[e] Low-flow nasal cannula is ≤6 L/min, and high-flow nasal cannula is >6 L/min.

Table 8: Guidelines for management of immune effector cell-associated neurotoxicity syndrome (ICANS)

Grade	Presenting symptoms[a]	Concurrent CRS	No Concurrent CRS
Grade 1	ICE score 7-9[b] Or, depressed level of consciousness[c]: awakens spontaneously.	Management of CRS per Table 7. Monitor neurologic symptoms and consider neurology consultation and evaluation, per physician discretion.	Monitor neurologic symptoms and consider neurology consultation and evaluation, per physician discretion.
		Consider non-sedating, anti-seizure medicinal products (e.g., levetiracetam) for seizure prophylaxis.	
Grade 2	ICE score 3-6[b] Or, depressed level of consciousness[c]: awakens to voice.	Administer tocilizumab[i] per Table 7 for management of CRS. If no improvement after starting tocilizumab[i], administer dexAMETHasone[d] 10 mg intravenously every 6 hours if not already taking other corticosteroids. Continue dexAMETHasone use until resolution to Grade 1 or less, then taper.	Administer dexAMETHasone[d] 10mg intravenously every 6 hours. Continue dexAMETHasone use until resolution to Grade 1 or less, then taper.

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		Consider non-sedating, anti-seizure medicinal products (e.g., levetiracetam) for seizure prophylaxis. Consider neurology consultation and other specialists for further evaluation, as needed.	
Grade 3	ICE score 0-2[b] Or, depressed level of consciousness[c]: awakens only to tactile stimulus, or seizures[c], either: • any clinical seizure, focal or generalised that resolves rapidly, or • non-convulsive seizures on electroencephalogram (EEG) that resolve with intervention, or raised intracranial pressure: focal/local oedema on neuroimaging[c].	Administer tocilizumab[i] per Table 7 for management of CRS. In addition, administer dexAMETHasone[d] 10 mg intravenously with the first dose of tocilizumab[i], and repeat dose every 6 hours. Continue dexAMETHasone use until resolution to Grade 1 or less, then taper.	Administer dexAMETHasone[d] 10 mg intravenously every 6 hours. Continue dexAMETHasone use until resolution to Grade 1 or less, then taper.
		Consider non-sedating, anti-seizure medicinal products (e.g., levetiracetam) for seizure prophylaxis. Consider neurology consultation and other specialists for further evaluation, as needed.	
Grade 4	ICE score 0[b] Or, depressed level of consciousness[c] either: • patient is unarousable or requires vigorous or repetitive tactile stimuli to arouse, or • stupor or coma, or seizures[c], either: • life-threatening prolonged seizure (>5 minutes), or • repetitive clinical or electrical seizures without return to baseline in between,	Administer tocilizumab[i] per Table 7 for management of CRS. As above, or consider administration of methylprednisolone 1000mg per day intravenously with first dose of tocilizumab[i], and continue methylprednisolone 1000 mg per day intravenously for 2 or more days.	As above, or consider administration of methylprednisolone 1000 mg per day intravenously for 3 days; if improves, then manage as above.

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	or motor findings[c]: • deep focal motor weakness such as hemiparesis or paraparesis, or raised intracranial pressure / cerebral oedema[c], with signs/symptoms such as: • diffuse cerebral oedema on neuroimaging, or • decerebrate or decorticate posturing, or • cranial nerve VI palsy, or • papilloedema, or • cushing's triad	Consider non-sedating, anti-seizure medicinal products (e.g., levetiracetam) for seizure prophylaxis. Consider neurology consultation and other specialists for further evaluation, as needed. In case of raised intracranial pressure/cerebral oedema, refer to institutional guidelines for management.

[a] Management is determined by the most severe event, not attributable to any other cause.
[b] If patient is arousable and able to perform Immune Effector Cell-Associated Encephalopathy (ICE) Assessment, assess: **Orientation** (oriented to year, month, city, hospital = 4 points); **Naming** (name 3 objects, e.g., point to clock, pen, button = 3 points); **Following Commands** (e.g., "show me 2 fingers" or "close your eyes and stick out your tongue" = 1 point); **Writing** (ability to write a standard sentence = 1 point; and **Attention** (count backwards from 100 by ten = 1 point). If patient is unarousable and unable to perform ICE Assessment (Grade 4 ICANS) = 0 points.
[c] Attributable to no other cause.
[d] All references to dexAMETHasone administration are dexAMETHasone or equivalent.

SUPPORTIVE CARE:

EMETOGENIC POTENTIAL:

- As outlined in NCCP Classification Document for Systemic AntiCancer Therapy (SACT) Induced Nausea and Vomiting- Available on the NCCP website

Teclistamab: Minimal **(Refer to local policy).**

Within NCIS regimens, antiemetics have been standardised by the Medical Oncologists and Haemato-oncologists and information is available in the following documents:

- NCCP Supportive Care Antiemetic Medicines for **Inclusion in NCIS** (Medical Oncology) - Available on the NCCP website
- NCCP Supportive Care Antiemetic Medicines for **Inclusion in NCIS** (Haemato-oncology) - Available on the NCCP website

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PREMEDICATIONS:

- Pre-medication with corticosteroids, antihistamines and antipyretics must be administered 1 to 3 hours before each dose of the teclistamab step-up dosing schedule (see Table 1) to reduce the risk of cytokine release syndrome, as suggested in Table 9
- Administration of premedication may also be required prior to administration of subsequent doses of teclistamab for the following patients:
    - Patients who repeat doses within the teclistamab step-up dosing schedule due to dose delays (Table 3), or
    - Patients who experienced CRS following the previous dose (Table 6)

Table 9: Suggested premedications prior to teclistamab infusion

Drug	Dose	Route
dexAMETHasone	16mg	PO, 60 minutes prior to infusion
Chlorphenamine	10mg	IV bolus, 60 minutes prior to infusion
Paracetamol	1g	PO, 60 minutes prior to infusion

OTHER SUPPORTIVE CARE:

- **Immunoglobulin replacement** is recommended for all patients receiving teclistamab as they will quickly become hypogammaglobulinaemic when on treatment with an anti-BCMA bispecific antibody
- Antiviral prophylaxis is recommended for prevention of herpes zoster reactivation **(refer to local policy)**
- Tumour lysis prophylaxis **(Refer to local policy)**
- Anti-bacterial prophylaxis **(Refer to local policy)**
- Anti-fungal prophylaxis **(Refer to local policy)**
- Consider PJP prophylaxis **(Refer to local policy)**

ADVERSE EFFECTS:

- Please refer to the relevant Summary of Product Characteristics (SmPC) for details.
- **Teclistamab is subject to additional monitoring. Healthcare professionals are asked to report any suspected adverse reactions.**

REGIMEN SPECIFIC COMPLICATIONS:

- **CRS:** including life-threatening or fatal reactions, may occur in patients receiving teclistamab. Clinical signs and symptoms of CRS may include but are not limited to fever, hypoxia, chills, hypotension, tachycardia, headache, and elevated liver enzymes. Potentially life-threatening

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complications of CRS may include cardiac dysfunction, adult respiratory distress syndrome, neurologic toxicity, renal and/or hepatic failure, and disseminated intravascular coagulation (DIC). Treatment should be initiated with teclistamab according to the step-up dosing schedule (Table 1) to reduce risk of CRS, and pre-treatment with corticosteroids, antihistamine and antipyretics should be administered prior to each dose of the step-up dosing schedule to reduce risk of CRS. Patients who experience CRS following their previous dose should be administered pre-treatment corticosteroids, antihistamine and antipyretics prior to the next dose of teclistamab. Patients should be counselled to seek medical attention should signs or symptoms of CRS occur. At the first sign of CRS, patients should be immediately evaluated for hospitalisation. Treatment with supportive care, tocilizumab[i] and/or corticosteroids should be instituted, as outlined in Table 6 and 7 above. Treatment with teclistamab should be withheld until CRS resolves.

- **ICANS**: Serious or life-threatening neurologic toxicities, including ICANS may occur following treatment with teclistamab, patients should be monitored for signs or symptoms of neurologic toxicities during treatment and treated promptly. Patients should be counselled to seek medical attention should signs or symptoms of neurologic toxicity occur. At the first sign of neurologic toxicity, including ICANS, patients should be immediately evaluated and treated based on severity as outlined in Table 8 above. For ICANS and other neurologic toxicities, treatment with teclistamab should be withheld as indicated in Table 6 above. Due to the potential for ICANS, patients should be advised not to drive or operate heavy machinery during the teclistamab step-up dosing schedule and for 48 hours after completing the teclistamab step-up dosing schedule (Table 1) and in the event of new onset of any neurological symptoms.
- **Hepatitis B virus reactivation:** Hepatitis B virus reactivation can occur in patients treated with medicinal products directed against B cells, and in some cases, may result in fulminant hepatitis, hepatic failure, and death. Patients with evidence of positive HBV serology should be monitored for clinical and laboratory signs of HBV reactivation while receiving teclistamab, and for at least six months following the end of teclistamab treatment. In patients who develop reactivation of HBV while on teclistamab, treatment with teclistamab should be withheld as indicated in Table 6 and manage per local institutional guidelines.

DRUG INTERACTIONS:

- Current SmPC and drug interaction databases should be consulted for information.

COMPANY SUPPORT RESOURCES/Useful Links:

Please note that this is for information only and does not constitute endorsement by the NCCP

Patient card:

https://assets.hpra.ie/products/Human/39105/262e3cb3-6467-4525-90b8-7024697b34d2.pdf

REFERENCES:

1. Moreau P, et al. Teclistamab in Relapsed or Refractory Multiple Myeloma. N Engl J Med 2022;387:495-505

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3. Rodriguez-Otero et al. International Myeloma Working Group immunotherapy committee consensus guidelines and recommendations for optimal use of T-cell-engaging bispecific antibodies in multiple myeloma. Lancet Oncol 2024; 25: e205-16
4. Teclistamab (Tecvayli®). Summary of Product Characteristics. Accessed 27th August 2025. Last updated 21st October 2024. Available at: https://www.ema.europa.eu/en/documents/product-information/tecvayli-epar-product-information_en.pdf

Version	Date	Amendment	Approved By
1	14/10/2024		NCCP Plasma Cell Disorders CAG
1a	25/02/2025	Update to reimbursement status.	NCCP
2	10/04/2025	Amendment made to Table 1 and 2 (addition of footnote "e" regarding injection volume)	NCCP
3	29/09/2025	Reviewed. Inclusion of immunoglobulins in testing section. Table 3 updated as per SPC. Regimen updated as per NCCP standardisation.	Dr Patrick Hayden
4	19/03/2026	Reference added to regimen relating to NCCP regimen 00927 for two weekly maintenance dosing. Testing section and Other Supportive Care section updated. Patient card hyperlink updated.	Dr Patrick Hayden
4a	29/04/2026	Amended typographical error in indication.	NCCP

Comments and feedback welcome at oncologydrugs@cancercontrol.ie.

[i] This is an unlicensed indication for the use of tocilizumab in Ireland. Patients should be informed of this and consented to treatment in line with the hospital's policy on the use of unlicensed medication and unlicensed or "off label" indications. Prescribers should be fully aware of their responsibility in communicating any relevant information to the patient and also ensuring that the unlicensed or "off label" indication has been acknowledged by the hospital's Drugs and Therapeutics Committee, or equivalent, in line with hospital policy

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