

White Paper

At the Cutting Edge: Innovation in Haematological Cancer Treatment

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Acronyms

Table 1: Acronyms for haematological cancers

ACRONYM	HAEMATOLOGICAL CANCER
ALL	Acute lymphoblastic leukaemia
AML	Acute myeloid leukaemia
CLL	Chronic lymphocytic leukaemia
CML	Chronic myeloid leukaemia
DLBCL	Diffuse large B-cell lymphoma
FL	Follicular lymphoma
HL	Hodgkin lymphoma
MDS	Myelodysplastic syndromes
MM	Multiple myeloma
MPN	Myeloproliferative neoplasms
NHL	Non-Hodgkin lymphoma
SLL	Small lymphocytic lymphoma

Introduction

Haematological cancers are a diverse group of diseases that include leukaemias, lymphomas and multiple myeloma. Cancer is the second leading cause of death globally, and haematological malignancies account for a substantial share of this burden, at 6.6% of cancer cases and 7.2% of cancer-related deaths. However, these figures mask substantial variation. While decades of therapeutic progress have transformed some haematological cancers into chronic conditions, outcomes remain poor in others where effective, tolerable and accessible treatments are limited, particularly for patients with aggressive, relapsed or refractory disease.

These clinical challenges persist alongside a challenging commercial environment. In both haematological and solid cancers, innovators face increasingly crowded treatment landscapes, while health systems remain under pressure with limited capacity to adopt innovation. Nevertheless, oncology remains commercially attractive: it leads all therapy areas by deal volume, featuring in almost 30% of the 1,360 pharmaceutical deals (excluding funding deals) in H1 2026,¹ and also remains the highest-value therapy area within the pharmaceutical market.² Haematological cancers account for a significant share of this market, at \$75 billion in the year to Q2 2026 at ex-manufacturer list prices.³

In this white paper, we examine where unmet need persists in haematological cancers, and how scientific innovation is reshaping the treatment landscape. We include a deep dive into chimeric antigen receptor (CAR) T-cell therapies, where arguably both the curative promise and practical barriers are greatest, before providing a perspective on the market outlook and the capabilities that innovators will require to translate scientific progress into patient impact.



Uneven unmet need in haematological cancers

HAEMATOLOGICAL MALIGNANCIES ARE A DIVERSE AND COMPLEX GROUP OF DISEASES

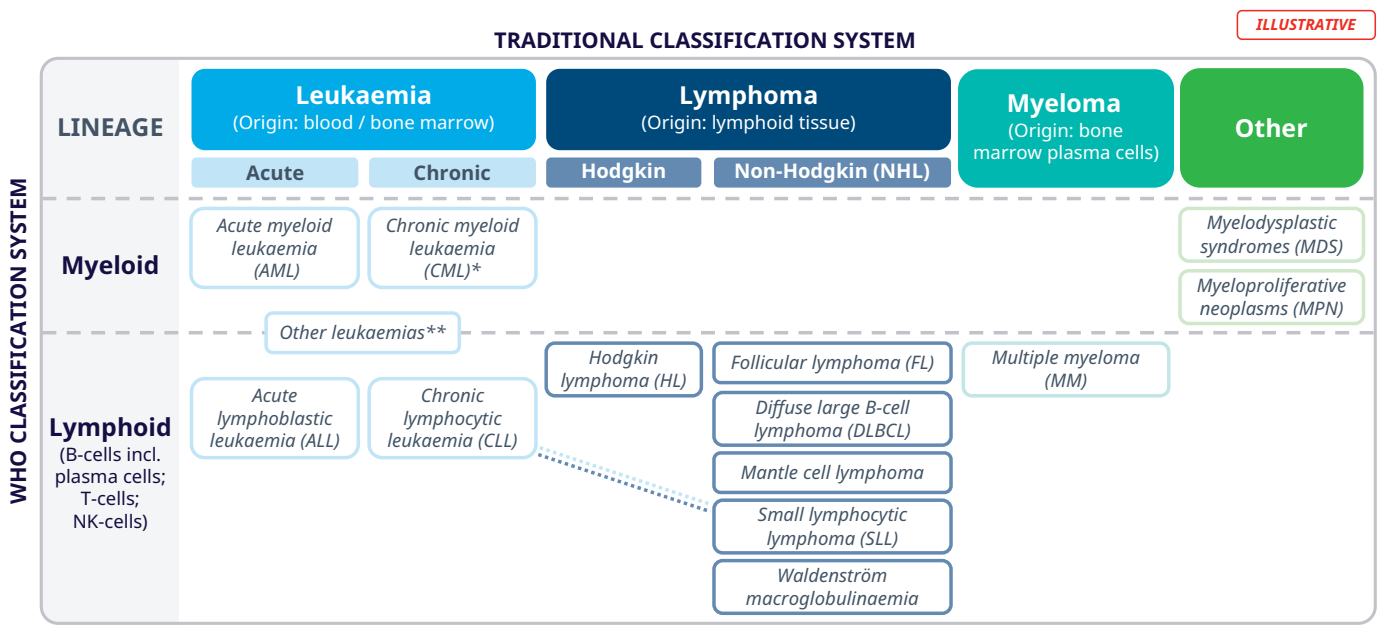
While all haematological cancers affect the production and function of blood cells, there are many different types and subtypes, each with unique underlying biology. This leads to a vast range of disease courses, treatment options, and outcomes for patients. For example, these cancers can be indolent or aggressive; prevalent or rare; some (such as leukaemia) are relatively common in children but others (such as multiple myeloma) mainly develop in older populations. As a result, classifying haematological malignancies is not straightforward.

Traditionally, haematological malignancies have been classified by the site of initial cancer detection,

resulting in three main categories: leukaemia, lymphoma, and multiple myeloma. However, the World Health Organisation’s (WHO’s) classification system, introduced in 2001 and now in its 5th edition (2022), groups the malignancies by cell lineage, broadly as either myeloid or lymphoid neoplasms.^{4,5} Figure 1 provides an overview of how the main malignancies are classified.

In practice, both systems are still used for different purposes, but the WHO’s has far more clinical relevance due to being based on biology and clinical features. For example, chronic lymphocytic leukaemia (CLL) and small lymphocytic lymphoma (SLL) were traditionally classified separately due to having different primary sites at diagnosis, but the WHO considers them to be the same disease as they are biologically identical, and this now informs treatment recommendations for CLL/SLL.

Figure 1: Haematological malignancies can be classified by the site of initial detection or by cell lineage



Notes: *Classified under MPN by the WHO **Some leukaemias are classified under MPN; illustrative; not exhaustive; selected cancer types shown. CLL and SLL are considered the same disease under the WHO classification system

Sources: WHO Classification of Tumours (5th Edition); Haematolymphoid Tumours (2024) Table of Contents⁶; Haematological Malignancy Research Network⁷; IQVIA Thought Leadership

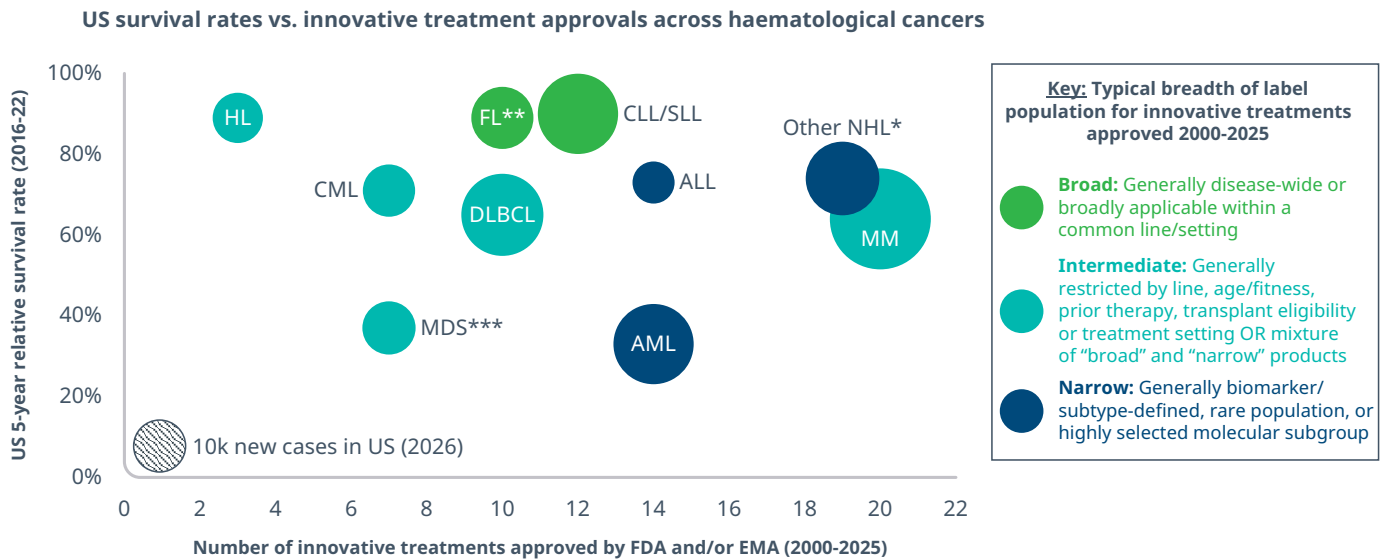
UNMET NEED IS PARTICULARLY HIGH IN AGGRESSIVE CANCERS AND RELAPSED PATIENTS, BUT TAKES DIFFERENT FORMS ACROSS MALIGNANCIES

The diversity across haematological malignancies has also led to huge variation in both historic progress in treatment development and patient outcomes, illustrated in Figure 2. Overall, unmet need remains particularly high in aggressive cancers and relapsed patients, but it also varies by malignancy subtype, patient age, and patient frailty. It should be noted that survival rate data has an inherent lag and therefore does not reflect the newest therapies. The large number of approvals for “other non-Hodgkin lymphoma (NHL)” in Figure 2 is partly due to this category including many distinct diseases.

Outcomes are particularly poor in adults with aggressive leukaemias, especially acute myeloid leukaemia (AML) and T-cell acute lymphoblastic leukaemia (ALL). Most treatments approved for AML since 2000 are restricted to narrow, often biomarker-selected populations, reflecting the genetic heterogeneity of the disease and meaning that options remain limited for many patients. Poor outcomes in myelodysplastic syndromes (MDS) are also partly driven by the risk of progression to AML. Within AML, unmet need is greatest in relapsed or refractory disease, where survival is often less than one year,⁹ as well as in some subpopulations, such as those with TP53-mutated disease. Unmet need is also acute among young, fit AML patients who could tolerate intensive therapy but have few effective options available.

The diversity across haematological malignancies has led to huge variation in treatment development and patient outcomes.

Figure 2: Unmet need and innovation activity are not aligned in haematological cancers



Note: Refer to Table 1 for acronyms. Survival rates have an inherent lag. 2016-2022 refers to the years in which patients were diagnosed. Innovative treatments include unique active substances approved by the FDA and/or EMA from 2000-2025 for direct treatment of the haematological malignancy, counted once per malignancy. Combinations and regimens are not counted separately unless they introduce a distinct new active substance or fixed-dose treatment product. Generics, biosimilars, transplant-conditioning, stem-cell mobilisation and supportive-only products are excluded. Products withdrawn from the market as of August 2026 are excluded. Population breadth is based on an average across products for each malignancy. *Other NHL defined as NHL excluding CLL/SLL, DLBCL, FL but 5-year survival rate reflects all NHL. Sources: U.S. SEER[®]; **FL new cases are based on a 2025 SEER-derived projection from Ta et al., 2023, Blood; ***MDS survival rate based on Sekeres & Taylor, 2022, JAMA; cancer.org; NCI cancer drug lists; FDA; EMA/European Commission; IARC/WHO haematolymphoid classification; other secondary sources; IQVIA Thought Leadership analysis

Considerable unmet need also persists in some aggressive lymphomas, such as diffuse large B-cell lymphoma (DLBCL). DLBCL accounts for approximately 30% of lymphomas¹⁰ and while many patients can be cured, those who relapse after frontline treatment face poor outcomes.¹¹ However, for indolent NHL, such as follicular lymphoma and CLL/SLL, the prognosis is generally good, and median survival can be up to 20 years.¹²

In multiple myeloma, the numerous therapies approved during recent decades have transformed outcomes. While it remains incurable, multiple myeloma can be considered a chronic condition for many patients.¹³ Treatment is often ongoing, and therefore quality of life during treatment becomes a critical consideration, shaped by factors such as side effects and monitoring requirements.

INNOVATORS FACE A RANGE OF CHALLENGES BUT ALSO HAVE REASON TO BE OPTIMISTIC

Rapid disease progression can complicate clinical development in aggressive malignancies such as acute leukaemias and DLBCL, due to the need for urgent treatment initiation. This limits the time available for clinical trial enrolment, and can lead to reduced trial participation among the sickest patients, potentially leading to improved outcomes in control arms and making treatment effects harder to detect.^{14,15} Advances in AML have also been limited by disease complexity, and meaningful progress in future may require therapies directed at a range of targets.¹⁶ CAR T-cell development for AML is further complicated by the lack of a tumour-specific antigen that can be targeted without also damaging healthy blood-forming cells.¹⁷

For multiple myeloma, recent progress creates a different set of challenges for clinical development. Long survival means that trials can run for many years, while the availability of numerous treatments can make it difficult to identify and enrol eligible patients.

There is therefore a need to shift endpoints away from overall survival and towards measures such as minimal residual disease (MRD). The FDA published draft guidance in January 2026 which supports the use of MRD as an endpoint,¹⁸ and in August 2026, the FDA granted the first multiple myeloma approval based on MRD-negative complete response.¹⁹ MRD is likely to play an increasingly central role in haematological cancer clinical trials going forward, and could also eventually inform clinical decision-making, for example to stop treatment after sustained MRD negativity, and restart if MRD is detected again.

MRD is likely to play an increasingly central role in haematological cancer clinical trials going forward.

Adoption of new therapies is also a challenge: even in countries with good availability of innovative medicines, often only a small proportion of eligible patients receive the most suitable available treatment. Reasons include limited reimbursement for high-cost therapies such as CAR T, and healthcare system capacity constraints due to monitoring and infrastructure requirements. For example, a 2025 IQVIA report found that 28% of CAR T-treating physicians in Italy cited lack of hospital capacity as a reason for patients not receiving treatment.²⁰ Moving complex therapies out of referral hospitals and into the community also creates challenges, particularly for those now approved in early lines. Referral rates can be low, as physicians struggle to navigate increasingly complex treatment options, and in some geographies, financial incentives may also have a role.

Nevertheless, the pace of scientific innovation across haematological cancers provides reason for continued optimism, as the following section explores.

The evolving innovative treatment landscape

INNOVATION IN TREATMENTS FOR HAEMATOLOGICAL INDICATIONS OFTEN PAVES THE WAY FOR PROGRESS IN SOLID TUMOURS

Historically, many highly innovative oncology treatments have initially been approved for haematological malignancies before expanding to solid tumours. This is true of the first chemotherapy treatments, the first antibody-drug conjugates (ADCs), and more recently, bispecific antibodies and CAR T-cell therapies, as illustrated in Figure 3. This is partly due to the underlying biology of the target, as well as the cancerous cells being more physically accessible. As a result, many of the current advances in treatment development for haematological indications may have implications for oncology more broadly in the future.

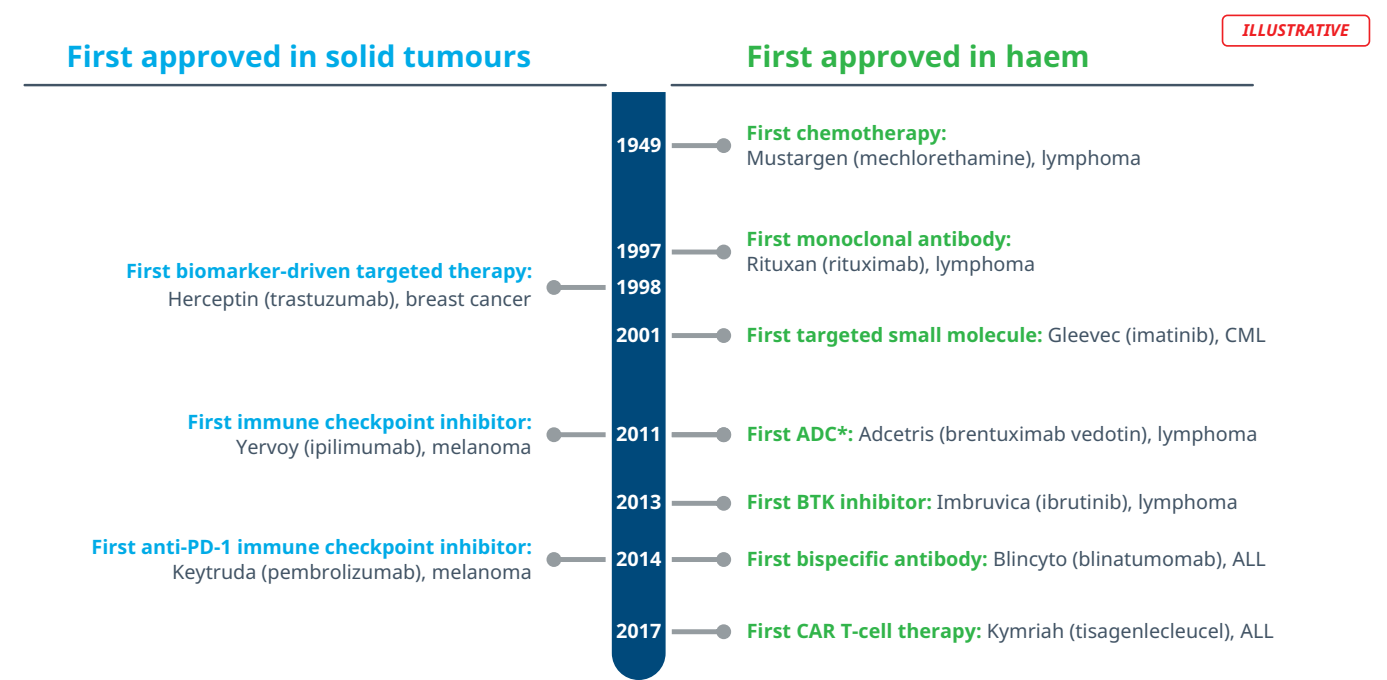
RECENT YEARS HAVE BROUGHT SUBSTANTIAL PROGRESS IN MANY MODALITIES

Innovative modalities have significantly expanded the range of effective treatment options for

haematological cancers. These include targeted small molecules such as Bruton tyrosine kinase (BTK) inhibitors, ADCs, bispecific antibodies (currently specifically T-cell engagers which bind both CD3 on T cells and a tumour antigen), and CAR T-cell therapies.

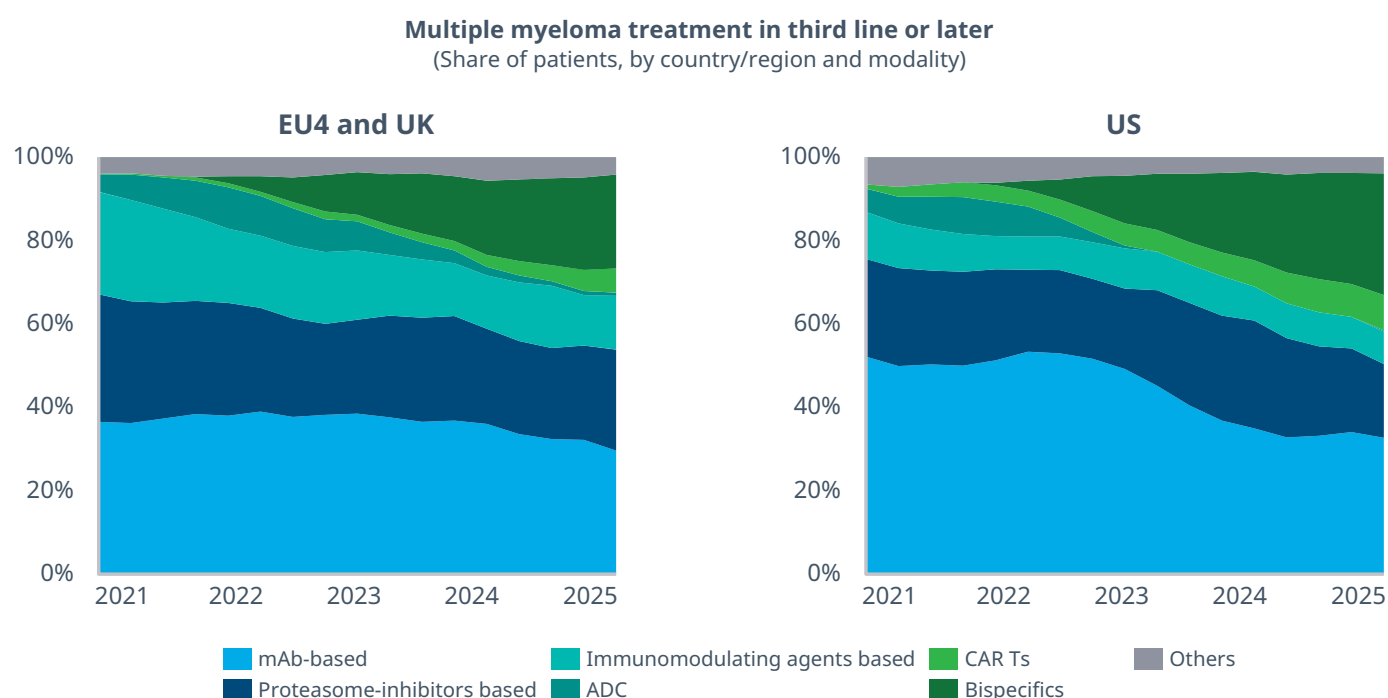
This rapid expansion has also created intense competition between therapeutic classes, such as bispecific antibodies and CAR T-cell therapies. IQVIA's Oncology Dynamics data in Figure 4 illustrates the competitive dynamics at third line or later in multiple myeloma. These dynamics vary considerably by line of therapy and will continue to evolve over time: for example, as CAR T is now also approved in second line for multiple myeloma, its use is likely to shift to earlier lines. Determining where to position each modality within the treatment paradigm will be a central challenge for innovators, particularly in more indolent diseases such as follicular lymphoma, where the standard of care sequence is less fixed and often tailored to individual patients.

Figure 3: Milestone oncology approvals have often initially been for haematological malignancies



Notes: Refer to Table 1 for acronyms. Illustrative; not exhaustive; based on FDA and EMA approvals only; *Mylotarg (gemtuzumab ozogamicin) was the first ADC to be approved by the FDA, in 2000 for AML, but was voluntarily withdrawn in 2010, and then re-approved in 2017. Approval shown is the first FDA or EMA approval
Source: IQVIA Thought Leadership; desk research

Figure 4: Competitive dynamics between novel modalities in multiple myeloma (third line or later)



Note: Charts show quarterly MAT data
Source: IQVIA Oncology Dynamics Dec 2025

There is considerable potential to make better use of many existing therapies, especially advanced modalities. This could involve moving treatments into earlier lines to control the disease earlier and alter the disease trajectory; improving identification of patient subpopulations most likely to benefit; or including more therapies within combination regimens. For example, when CAR T was moved into second-line treatment for B-cell lymphoma, outcomes improved significantly, and for oncology more broadly, the FDA is attempting to incentivise sponsors to seek approval in earlier treatment settings through Project FrontRunner.²¹

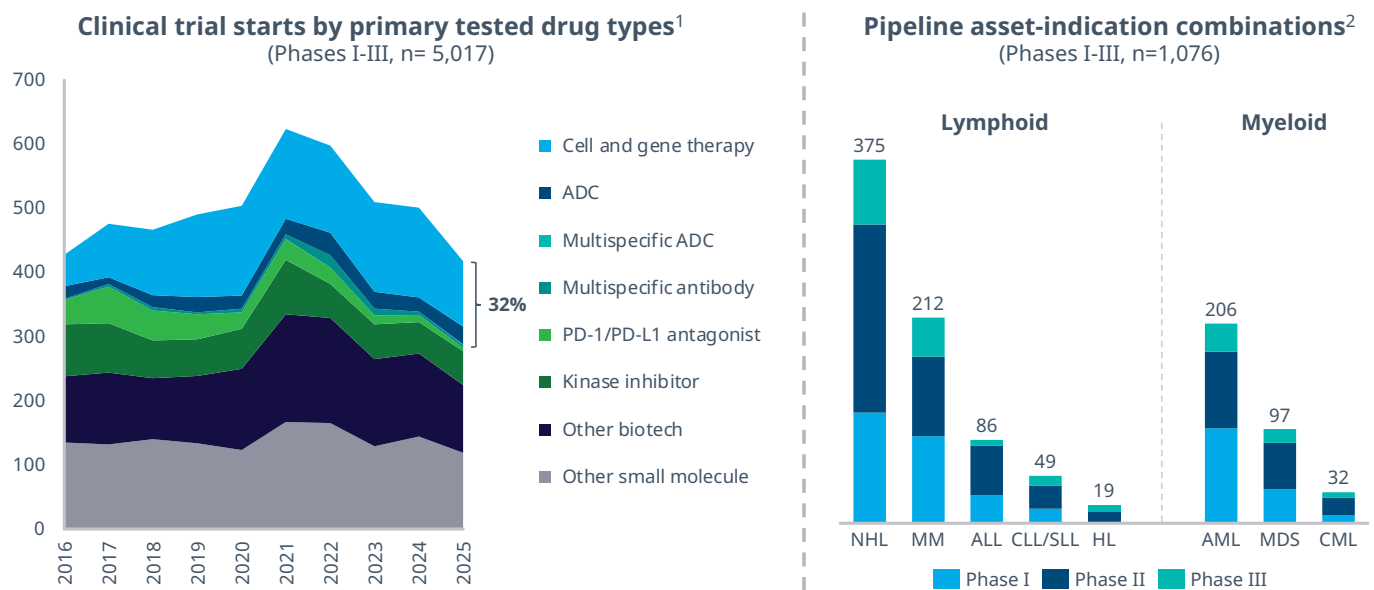
There is considerable potential to make better use of many existing therapies, especially advanced modalities.

FUTURE INNOVATION WILL LARGELY BE DRIVEN BY IMPROVEMENTS TO EXISTING TECHNOLOGIES

The recent wave of innovation will form the basis for future progress. As the left-hand side of Figure 5 illustrates, 32% of haematological cancer clinical trial starts in 2025 were for novel modalities, defined here as cell and gene therapies, ADCs, and multispecific antibodies. This has risen from 17% in 2016, and cell and gene therapies account for the majority of this segment.

At an asset level, the phase I-III pipeline comprises 667 unique assets, most of which are combinations with already-marketed substances and/or chemotherapy. The right-hand side of Figure 5 shows the pipeline by indication, where each asset is counted once per indication in which it is being developed, resulting in 1,076 asset-indication combinations. Activity is unevenly distributed across malignancies: NHL has the highest number of assets, partly because it encompasses many distinct diseases. Other indications with large pipelines include both well-served malignancies, such as multiple myeloma, and those with few treatment options, such as AML. The AML and MDS pipelines overlap substantially, with 60% of phase I-III MDS assets also in development for AML.

Figure 5: The innovative clinical pipeline for haematological malignancies



Notes: Refer to Table 1 for acronyms. Innovative pipeline only; generics and biosimilars are excluded. Clinical trials are industry-sponsored only. Assets tested in multiple indications are counted once per indication. Assets also tested in solid tumours are shown only for their haematological indication. Asset count includes combination therapies.

Sources: (1) Citeline Trialtrove, Jan 2026; IQVIA Institute, Feb 2026; (2) IQVIA Analytics Link, accessed June 2026

Protein degraders represent one promising new modality which leverage existing targets. For example, BTK degraders, which build on the established class of BTK inhibitors, are already in late-stage trials in relapsed or refractory CLL/SLL, as well as earlier-stage trials in several NHL subtypes. They are part of a wider expansion of proteolysis-targeting chimeras (PROTACs), which have considerable potential to help overcome resistance to small molecule inhibitors.²²

However, further progress will also require new targets. While targets such as CD19, CD20 and BCMA are now well established, many patients relapse because of treatment resistance, including antigen escape. New targets could provide alternative ways to recognise and treat resistant or heterogeneous tumour cells, while more tumour-selective targets could potentially improve efficacy and reduce toxicity to healthy tissues. In addition, combining new targets with established ones could further reduce the likelihood of antigen escape. Where early-stage trials prove successful, the next step will be expansion into other modalities and indications.

Further progress will require new targets.

For example, GPRC5D is a key new target in multiple myeloma, offering an alternative approach for patients previously treated with BCMA-directed treatments. As of September 2026, Talvey (talquetamab) is the only GPRC5D-targeted therapy approved by the FDA and EMA, in late-line relapsed or refractory multiple myeloma. GPRC5D is also being incorporated into trispecific antibodies, which are emerging as a key future modality.

Trispecific antibodies build on the success of bispecific antibodies by engaging three targets simultaneously, although identifying the most effective target combinations is a challenge for innovators. There is considerable clinical development activity here, which is currently largely early-stage. However, two assets are known to have entered phase III development, both targeting BCMA, GPRC5D and CD3 in relapsed/refractory multiple myeloma: Johnson & Johnson's JNJ-79635322,²³ and IBI3003 developed by Innovent Biologics,²⁴ a Chinese biopharmaceutical company.

New approaches to combination therapy represent another important area of innovation. Companies are increasingly trialling chemotherapy-free and low-intensity chemotherapy combinations in acute leukaemias, building on regimens such as azacitidine and venetoclax in AML, which a phase II trial found to be similarly effective to intensive chemotherapy in fit patients.²⁵ There is also growing interest in fixed-duration combinations, which offer patients breaks from therapy and are already well established in CLL/SLL,²⁶ but still emerging in other malignancies. Finally,

menin inhibitors feature in several promising first-line combination trials.²⁷ The FDA has approved two menin inhibitors, Revuforj (revumenib) and Komzifti (ziftomenib), as monotherapies for biomarker-defined populations with relapsed or refractory AML, but a menin inhibitor combination could potentially establish a new targeted first-line treatment option for defined AML subgroups.

Innovation is also advancing rapidly in CAR T-cell therapy. This is explored in detail below.

Deep dive: The next era for CAR T-cell therapies

CAR T-CELL THERAPIES OFFER UNRIVALLED EFFICACY AND CURATIVE POTENTIAL, BUT HAVE ALSO FACED EXTENSIVE CHALLENGES TO DATE

Nearly a decade after the first CAR T-cell therapy became commercially available in 2017, CAR T-cell therapies are now well established in the treatment of B-cell malignancies, including B-cell ALL and several lymphomas, as well as multiple myeloma. These therapies involve genetically engineering a patient's own T cells to express a CAR which targets a tumour antigen, expanding the cells, and reinfusing them to bind to and destroy the cancer cells. The curative potential of a single administration sets CAR T-cell therapies apart from other modalities.

The curative potential of a single administration sets CAR T-cell therapies apart from other modalities.

In the past, CAR T-cell therapies were reserved for late-line relapsed or refractory populations. By this point, patients have often accumulated treatment-related complications and organ damage, and the number and function of their T-cells (used to produce the CAR T) are reduced. Moving CAR T treatment earlier was therefore hypothesised to increase efficacy. As a result of subsequent clinical trials, CAR T-cell therapies successfully moved from fourth line and beyond into second line in some indications, such as B-cell lymphoma and multiple myeloma, with first-line clinical trials anticipated in some indications in the near future.²⁸

Despite this success, CAR T clinical development is also becoming more challenging. As CAR T becomes more widely administered, sponsors face growing difficulty in identifying CAR T-naïve patients in established markets such as the U.S. and Europe. Ethical considerations also complicate early-stage trial enrolment, as patients and clinicians may favour approved therapies with proven efficacy over those in clinical development. This has prompted a shift in clinical trial geography, with sponsors increasingly exploring regions such as Latin America and Asia-Pacific, and in some cases initiating first-in-human studies in China.²⁹

Regulatory standards are also tightening significantly. In the past, CAR T approvals have often been based on small, single-arm phase II studies, but regulatory bodies like the FDA and EMA are now expecting controlled trials for the next generation of CAR T-cell therapies, frequently against established CAR T-cell therapies as the standard of care. This constrains clinical trial geography, as the trial can only be run in countries where the comparator CAR T is already widely used. Where randomised trials are infeasible or unethical, external comparator arms are becoming an increasingly common alternative. These are derived from real-world data, and require deep methodological and regulatory expertise.³⁰

Regulatory standards for CAR T are tightening.

At the same time, CAR T-cell therapies are currently accompanied by substantial challenges for health systems, healthcare professionals (HCPs), and patients. Firstly, barriers to access remain significant, due in part to high costs and variable reimbursement policies. In addition, the personalised manufacturing process involves highly complex logistics and requires specialised infrastructure, as the patient's T-cells must be collected, transported to a specialised regional manufacturing facility, genetically engineered and grown, transported back, and reinfused. The duration of this process, known as vein-to-vein time, typically spans several weeks, during which time the patient's disease may progress significantly.³¹ Personalisation also means that the manufacturing process cannot benefit from economies of scale, as treating a greater number of patients requires more bespoke batches, rather than larger batches.³² Historically, these logistics have been coupled with requirements for hospital admission and close proximity to the treatment centre for around one month after infusion, adding to the burden on both health systems and patients.

Consequently, real-world uptake has had limitations, especially amid competition from other modalities such as bispecific antibodies. This competition reflects multiple trade-offs. As a personalised therapy, autologous CAR T has a high upfront cost and a long manufacturing time, unlike bispecific antibodies, as well as a requirement for lymphodepleting chemotherapy pre-treatment, and a greater risk of cytokine release syndrome (CRS) and neurotoxicity. However, crucially, CAR T-cell therapies offer the potential for medication-free remission, and best case, a cure, with a single infusion.

As with other advanced therapies, HCPs often struggle to identify appropriate patients for CAR T referral, and this challenge is becoming more pronounced as CAR T moves into earlier lines of therapy, where patients are more likely to be treated in community settings rather than at specialist centres. In response, sponsors are increasingly directing their efforts towards engaging and upskilling community centres.

Many patients drop off the CAR T treatment journey at various points. IQVIA's CAR T-Cell Monitor Q1 2026 Report found that in the U.S., over a quarter (27%) of patients who are referred to specialty CAR T centres do not ultimately receive the therapy. The reasons vary across patient groups, with the two leading reasons being patient refusal and performance status. Oncologists at CAR T-cell centres report that patients who decline CAR T-cell therapy often do so because of logistical challenges, concerns about safety or side effects, and limited family or social support, underlining the importance of manufacturer-provided patient support programmes.³³

HOWEVER, EVOLVING CARE MODELS HELP TO ALLEVIATE SOME OF THESE CHALLENGES

Practical aspects of CAR T delivery are evolving, helping to reduce the burden on both patients and treatment centres. Outpatient administration is becoming more common in the U.S., for example, with some centres even treating selected cases of low-grade CRS in the outpatient setting.³⁴ This shift towards outpatient care is supported by improved management of toxicities and the growing use of CAR T-cell therapy in less severely ill patients. However, it is also driven in part by financial incentives relating to how hospitals are reimbursed for CAR T treatment in the U.S.. This contrasts to many other countries such as in Europe, where reimbursement systems often incentivise inpatient care, despite being costly for payers and more burdensome for patients.³⁵

Monitoring requirements are also being streamlined, particularly in the U.S., with the FDA shortening follow-up periods for some products in 2025 from four weeks to two.^{36,37} Continuous wearable monitoring and centralised virtual nursing are increasingly supporting hospital-at-home models and outpatient CAR T delivery, enabling continuous toxicity surveillance and rapid escalation of care.^{38,39}

INNOVATION IN CAR T TECHNOLOGY MAY ALSO HELP TO ADDRESS CURRENT CHALLENGES

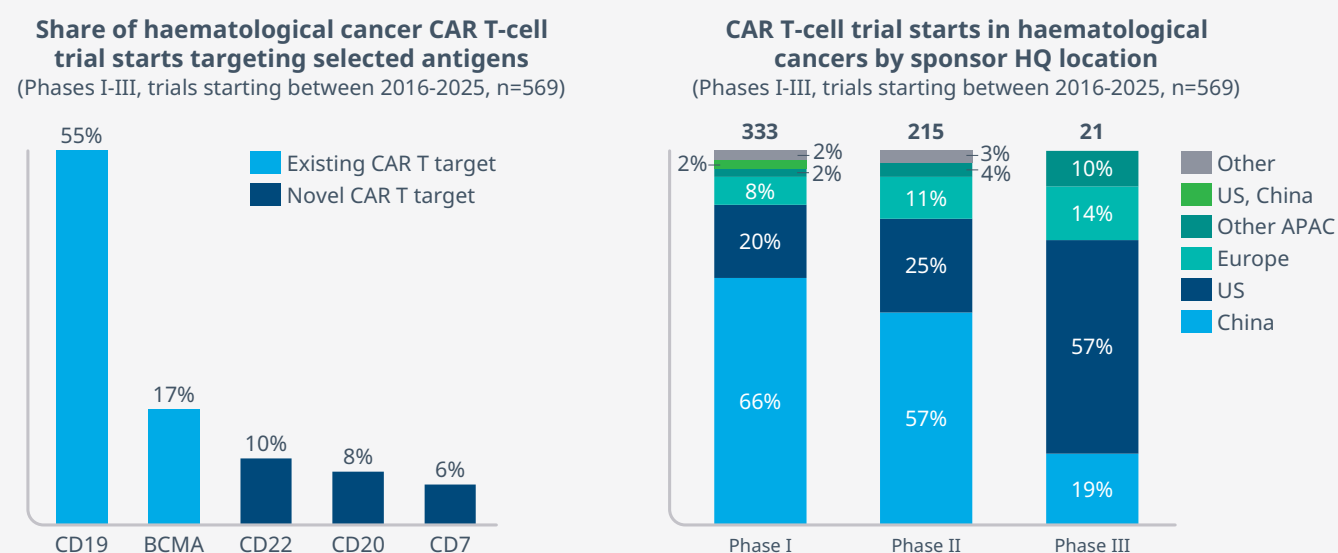
Many next-generation CAR T-cell therapies are already in development, and these are generally expected to outperform existing ones. Key areas of focus include new antigen targets and/or dual-target constructs; advances in ex vivo approaches; and the first in vivo CAR T-cell therapies, which offer a lot of promise despite being very early-stage.

Many next-generation CAR T-cell therapies are already in development.

All CAR T-cell therapies currently approved by the FDA and EMA target either CD19 or BCMA. These antigens featured in 55% and 17% of the phase I-III CAR T haematological cancer clinical trials started between 2016-2025 respectively,⁴⁰ as illustrated in Figure 6, but a substantial share of clinical development is directed at alternative antigens such as CD22, CD20 and CD7. These could extend CAR T to additional haematological cancers and provide options for patients who relapse after treatments that target CD19 or BCMA.

In China, the first CAR T-cell therapy directed at an antigen other than CD19 or BCMA was approved in June 2026.⁴¹ This CLDN18.2-directed therapy, developed by the Chinese company CARsgen Therapeutics, is also the world's first CAR T to be approved for a solid tumour, and is indicative of a broader trend: China is becoming a major source of CAR T innovation. Figure 6 shows that a large proportion of haematological cancer CAR T trials are being sponsored by China-headquartered companies, particularly in phases I and II. However, most of this trial activity remains domestic: across all therapy areas, 88% of clinical trials sponsored by China-headquartered companies are conducted only in China.⁴² Therefore while China-headquartered sponsors could account for a significant share of the next generation of CAR T-cell therapies, it remains to be seen in which markets these will gain approval and launch.

Figure 6: Clinical trial starts for CAR T-cell therapies in haematological cancers



Notes: Scope includes industry-sponsored, interventional phase I-III clinical trials started between 2016-2025; excludes medical devices, generics and biosimilars. Some CAR T-cell therapies may target more than one antigen; selected antigens shown based on extensively-studied haematological targets.⁴³ Therefore percentages do not sum to 100%. "Existing CAR T target" denotes a target of FDA/EMA-approved CAR T-cell therapies. Sponsor HQ location classified as "US, China" for trials with two sponsors, with HQ in US and China respectively.

Source: Cyteline Trialtrove Dec 2025; IQVIA Thought Leadership analysis

INNOVATION IN EX VIVO CAR T

Within ex vivo CAR T, several avenues of innovation are being pursued. These include dual-target therapies, directed at both CD19 and CD20 for example, which aim to minimise the risk of antigen escape and relapse. Kite's decision to compare its investigational rapidly-manufactured dual-target therapy, KITE-753, to its own approved product, Yescarta (axicabtagene ciloleucel), in a randomised phase III trial, signals high expectations for this approach.⁴⁴ KITE-753 is designed to not only improve efficacy through dual targeting, but also to preserve younger, perhaps fitter T-cells through accelerated manufacturing, with the potential to reduce toxicity.⁴⁵ Allogeneic (off-the-shelf) CAR T-cell therapies are also in development, such as Allogene Therapeutics' cema-cel, currently in a pivotal phase II trial.⁴⁶ These remove the need for patient-specific manufacturing, thereby simplifying logistics, reducing delays and potentially reducing costs.

INNOVATION IN IN VIVO CAR T

While the emerging field of in vivo CAR T-cell therapy is currently in its very early stages, if successful, it has the potential to be transformative and entirely redefine CAR T. Unlike ex vivo approaches, in vivo CAR T seeks to engineer immune cells directly within the patient's body, eliminating the need for cell collection and personalised manufacturing. In vivo approaches also typically avoid lymphodepleting chemotherapy, which is used to prepare patients for autologous CAR T but can cause severe side effects, particularly infections.⁴⁷ In vivo CAR T could therefore remove many of the barriers currently faced by CAR T, including reliance on specialised laboratory infrastructure and lengthy manufacturing processes. As a result, it could dramatically improve scalability and expand access across geographies.

Two distinct technological platforms are currently being investigated, each with very different clinical development processes:

- **Viral vector-based therapies**, which integrate the CAR transgene into the genome, and therefore enable stable and potentially permanent CAR expression. However, genomic integration creates a risk of delayed effects, including insertional mutagenesis, and therefore requires 15 years of monitoring and follow-up.
- **RNA-based therapies**, which typically deliver CAR-encoding RNA using lipid nanoparticles, producing transient CAR expression without genetic modification. While these have a favourable long-term safety profile, there are some concerns around persistence and potentially also efficacy, leading to questions around their suitability for oncology.

Despite being very early in development, in vivo CAR T is already attracting high levels of interest and investment from many large pharmaceutical companies. For example, Eli Lilly acquired Kelonia Therapeutics in April 2026, due to the promising early-stage clinical data for Kelonia's phase I asset KLN-1010.⁴⁸ High-value acquisitions of other early-stage assets which may have no clinical data yet, including by companies with no prior experience in CAR T or even cell and gene therapies, signal widespread excitement about the future potential of in vivo CAR T.

High-value acquisitions signal widespread excitement about the potential of in vivo CAR T.

ALTERNATIVE CELL THERAPIES

Another new modality that could compete with CAR T-cell therapies is engineered natural killer (NK) cells: CAR-NK. These therapies combine NK cells' natural ability to destroy abnormal cells with engineered targeting of specific tumour markers, and they could offer scalable, off-the-shelf treatment with fewer serious immune-related side effects than CAR T. Haematological cancers are at the forefront of clinical development, but CAR-NK remains largely in early-phase development, with cell persistence remaining a central challenge.⁴⁹

SUCCEEDING IN THE CAR T SPACE

Successful CAR T development and commercialisation require careful, strategic planning, incorporating a number of key considerations:

- For clinical trials, strategic selection of countries is critical. This differs according to the indication, line of therapy, trial design, and regulatory requirements. Practice patterns vary by country, and the most suitable geographical footprint will depend on whether the trial needs to include commercial CAR T as the standard of care or include a high number of CAR T-naïve patients.
- Targeting smaller, well-defined patient populations may offer a pragmatic route to initial market access, with scope to broaden indications over time. Focusing on improving tolerability and reducing toxicity will be essential.
- Differentiation from competing modalities such as bispecific antibodies, which may be seen as less burdensome and less costly, requires evidence on the depth and durability of response, the translation into long-term patient benefit, and potential lifetime cost advantages, together with a clear definition of the subpopulations likely to benefit the most.
- As CAR T moves to earlier lines, enabling a larger number of sites to deliver treatment is a key next step. Expanding engagement to centres beyond traditional academic centres, especially in community settings, will therefore become increasingly important. Medical affairs teams could help to achieve this.
- Digital monitoring technologies and self-reported patient data can support the expansion of outpatient care. As well as reducing the burden on patients and health systems, remote monitoring also helps to de-risk the expansion of CAR T delivery from academic centres to less experienced centres. Manufacturers could implement this technology through partnerships, not only in commercial settings but also in clinical trials.
- Close collaboration with health systems supports the integration of CAR T-cell therapies into existing care pathways, particularly given their divergence from conventional treatment models. Innovative financing mechanisms may also be required to address cost concerns.

CONCLUSION

CAR T-cell therapies will continue to have a critical role in the treatment of haematological cancers, provided that they keep evolving. While they face more competition from bispecific antibodies in multiple myeloma and lymphoma than in leukaemia, the defining advantage of CAR T-cell therapies remains their potential as a one-off, curative intervention. Overcoming barriers to access and demonstrating clear advantages over competing therapies will be essential to their future success.

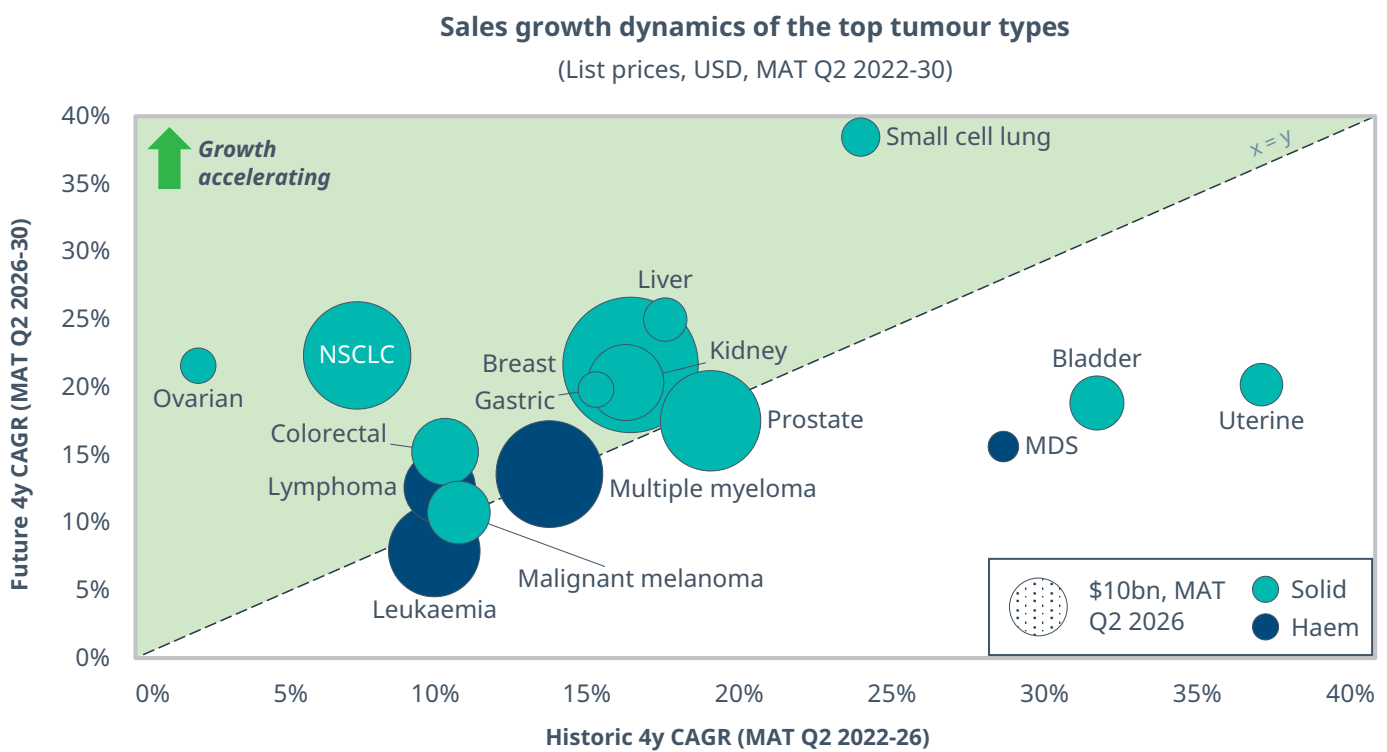
The market outlook for haematological cancers

From a commercial perspective, oncology remains the largest therapeutic area by global market size, worth \$293 billion at ex-manufacturer list prices (2026, MAT Q2). Haematological cancers account for 26% of the oncology market, at \$75 billion, and have forecast compound annual growth of 12% for 2026 to 2030 (MAT Q2). This is in line with their historic CAGR, which was also 12% (2022-26, MAT Q2), and

remains well above the expected growth of the overall pharmaceutical market.⁵⁰ It should be noted that these figures may underestimate the market size and growth, as CAR T-cell therapy sales are not fully captured in every country.

Figure 7 indicates that following strong market growth in recent years, MDS is expected to experience growth rates decelerating in the next four years, as is leukaemia. Despite this, MDS is forecast to remain the fastest-growing market within haematological cancers, followed by multiple myeloma and lymphoma.

Figure 7: Historic and forecast oncology market growth by malignancy



Notes: CAR T sales not fully captured in every country, likely leading to an underestimate in sales and growth rates for haematological cancers. “Top tumour types” based on MAT Q2 2026 sales. CAGR = compound annual growth rate; NSCLC = non-small cell lung cancer; Leukaemia includes CML, CLL, AML, ALL and Other Leukaemia; Lymphoma data includes NHL and HL; sales at ex-manufacturer list prices; constant exchange rate.
Source: IQVIA Thought Leadership, IQVIA MIDAS Disease Q2 2026, IQVIA Analytics Link (accessed Sept 2026)

How to overcome the challenges as an innovator and succeed

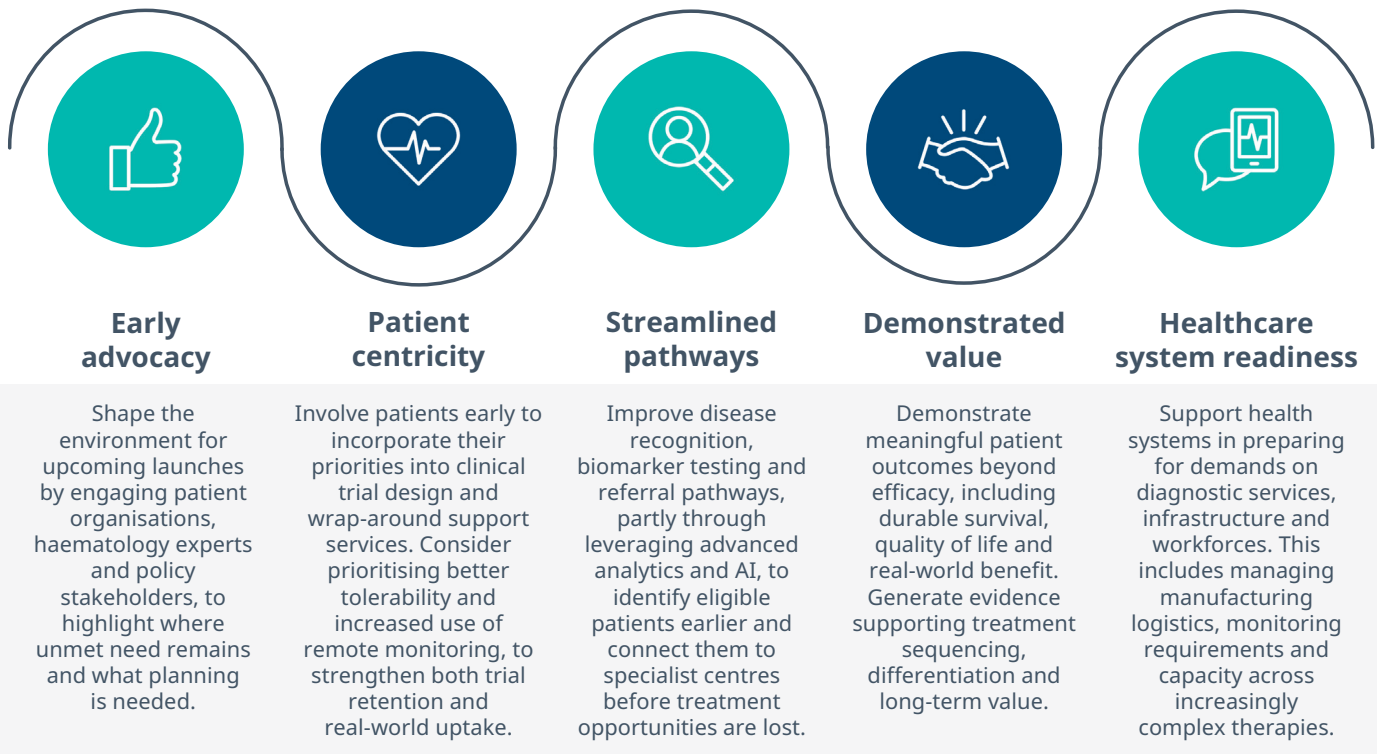
Scientific innovation continues to transform the treatment landscape across haematological cancers. However, as discussed throughout this paper, the factors determining success are evolving. While efficacy, regulatory approval and reimbursement remain essential, they are rarely sufficient on their own. Competitive advantage is shifting towards a broader set of capabilities, including identifying eligible patients, securing a place in the treatment pathway, reducing uncertainty for decision-makers, and enabling adoption within increasingly constrained healthcare systems.

While efficacy, regulatory approval and reimbursement remain essential, they are rarely sufficient on their own.

Moreover, haematological cancers must not be viewed as a single market. The challenges associated with developing and commercialising a therapy in relapsed AML differ markedly from those in multiple myeloma, CLL/SLL, DLBCL or rarer malignancies. Disease biology, patient populations, line of therapy, unmet need, competitive intensity and health system requirements all influence what success looks like in practice.

Several common themes emerge across haematological cancers, summarised in Figure 8. While companies must tailor their clinical and commercial strategies to the specific realities of individual diseases and patient populations, a number of broader principles consistently influence whether innovation reaches patients and achieves sustained adoption. The following five success factors represent capabilities that are relevant across the wider haematological cancer landscape and can help innovators maximise both patient impact and commercial success.

Figure 8: Succeeding with innovation in haematological cancers



Source: IQVIA Thought Leadership

EARLY ADVOCACY

Future markets must be built

As innovation continues at pace across haematological cancers, successful commercialisation depends on shaping the environment into which new therapies will launch. This is particularly important when innovation challenges existing treatment paradigms, introduces unfamiliar modalities, or requires changes to established care pathways. Engaging patient organisations, haematology experts and policy stakeholders can help build awareness of where existing therapies leave unmet need and impact quality of life, as well as ensure that future innovation is reflected in clinical guidance, reimbursement discussions and health system planning. The organisations that participate in these conversations early are often better positioned to translate scientific progress into clinical adoption.

PATIENT CENTRICITY

Place patients at the heart of development and delivery

Patients face numerous challenges, including side effects and monitoring requirements that affect quality of life, a high burden placed on their caregivers, and long-term consequences of treatment. Involving patients early helps innovators to understand patients' priorities, design trials around practical realities, and capture relevant patient-reported outcomes in addition to clinical endpoints, as well as provide meaningful wrap-around support throughout the treatment journey. Developing therapies with improved tolerability will be one of the most important ways to improve quality of life, while also easing pressure on health systems through lower monitoring requirements. Greater use of remote patient monitoring, supported by AI data processing tools, could reduce the burden further. Innovators that build patient insight into development from the outset are more likely to see stronger trial enrolment and retention, and greater real-world uptake.

STREAMLINED PATHWAYS

Connect innovation with patients

Advances in precision medicine are increasing the importance of identifying the right patients at the right point in their treatment journey. Biomarker-driven approaches, more specialised treatment pathways and growing use of advanced therapies all rely heavily on disease recognition, diagnostic testing and referral networks. Moreover, as therapies move into earlier lines of treatment and eligible patients become more

dispersed across healthcare settings, manufacturers must support more systematic approaches to patient identification. Investments in biomarker readiness, referral optimisation and data-driven approaches, including advanced analytics and AI, can help ensure that eligible patients are identified earlier and connected to specialist centres before treatment opportunities are lost.

DEMONSTRATED VALUE

Prove long-term value

As therapeutic options expand, demonstrating efficacy alone is rarely enough to secure long-term success. Innovators need to show how therapies improve outcomes that matter to patients, clinicians, healthcare systems and payers. Durable survival, quality of life and real-world benefit are becoming increasingly important considerations, particularly as many haematological malignancies now require longer-term disease management. At the same time, evidence must help stakeholders understand who the target populations are, and where therapies fit within complex treatment pathways. Companies that generate evidence supporting treatment sequencing, differentiation and long-term value will be better placed to gain reimbursement and establish a sustainable role within clinical practice.

HEALTHCARE SYSTEM READINESS

Enable adoption

Regulatory approval does not automatically translate into patient access. Many innovative haematological cancer therapies are operationally complex and place significant demands on diagnostic services, specialist workforces, treatment centres and care pathways. As a result, healthcare system readiness is becoming an increasingly important determinant of successful adoption. Manufacturers should consider infrastructure, workforce requirements, monitoring processes, logistics and capacity constraints throughout development rather than after launch. This preparation should be guided by early, strategic decisions about country launch sequencing, to determine which health systems need to be ready. These decisions should in turn be informed by the wider policy environment, including the U.S. Administration's Most Favoured Nation (MFN) pricing policy. Manufacturers that actively support health systems in preparing for future innovation can help to accelerate adoption, improve patient access, and maximise the real-world impact of new therapies.

Conclusion

Many of oncology's most significant therapeutic advances have first been in haematological cancers, before expanding to solid cancers, and the modalities currently in development suggest that broadly this pattern will continue. Recent therapeutic progress has been transformational for some patient populations but highly uneven: outcomes still lag far behind in some aggressive malignancies such as AML, and in relapsed disease.

For many indications, meaningful innovation must now extend beyond efficacy and prioritise tolerability, scalability, and reduction in the burden placed on health systems and patients, as reflected in the direction of CAR T-cell therapy evolution. Innovators who incorporate both haematology-wide and indication-specific capabilities into their clinical and commercial strategies will be best-placed to capture the commercial opportunity, while easing pressure on healthcare systems and transforming outcomes for patients.



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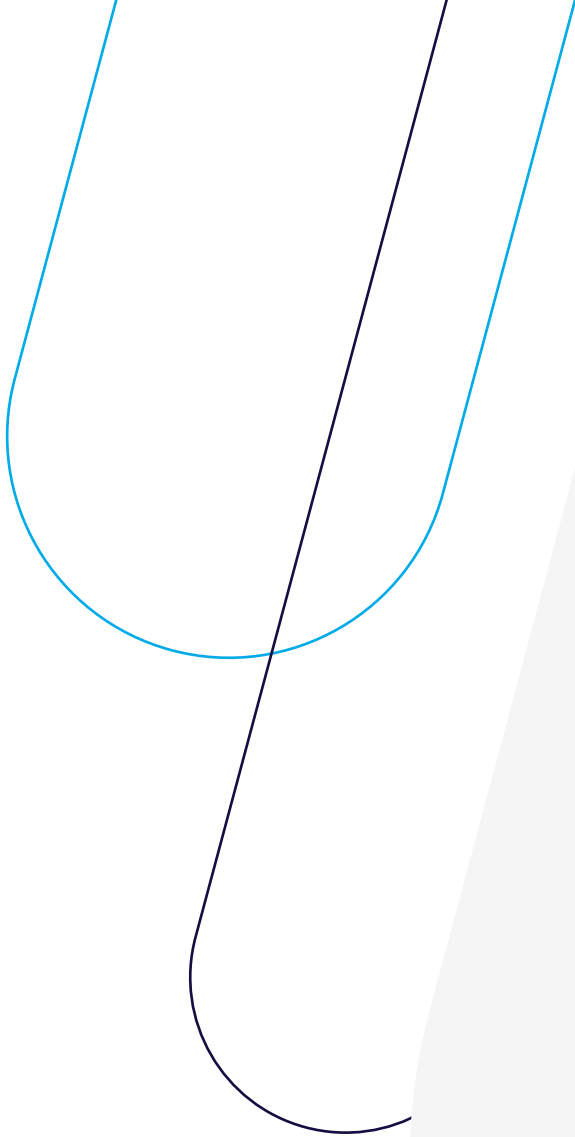
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