Medical Necessity Guidelines: Hematopoietic Stem-Cell Transplantation (HSCT) for the Treatment of Amyloidosis

Effective: December 13, 2017

Clinical Documentation and Prior Authorization Required

<table>
<thead>
<tr>
<th>Applies to:</th>
<th>Coverage Guideline, No Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Tufts Health Plan Commercial Plans products; Fax: 617.972.9409</td>
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<tr>
<td>☒ Tufts Health Direct – Health Connector; Fax: 888.415.9055</td>
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<tr>
<td>☒ Tufts Health Together – A MassHealth Plan; Fax: 888.415.9055</td>
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<tr>
<td>☒ Tufts Health Unify – OneCare Plan; Fax: 781.393.2607</td>
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<tr>
<td>☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404</td>
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<tr>
<td>☒ Tufts Health Freedom Plan products; Fax: 617.972.9409</td>
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Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

Stem cells are cells in the bone marrow that give the body a constant source of blood cells. Stem cell transplants are used to resupply the bone marrow when it has been destroyed by disease, chemotherapy, or radiation. Depending on the source of the stem cells, this procedure may be called a bone marrow transplant, a peripheral blood stem cell transplant, or a cord blood transplant (American Cancer Society, 2007).

Hematopoietic stem cell transplantation (HSCT) is a rapidly evolving technique that offers a potential cure for hematologic cancers (leukemias, lymphomas, myeloma) and other hematologic disorders (e.g., primary immunodeficiency, aplastic anemia, myelodysplasia). HSCT may be autologous or allogeneic; bone marrow, peripheral blood, or umbilical cord stem cells may be used. Peripheral blood has largely replaced bone marrow as a source of stem cells, especially in autologous HSCT, because stem cell harvest is easier and neutrophil and platelet counts recover faster. Umbilical cord HSCT has been mainly restricted to children because the number of stem cells is low (Merck Manual, 2006).

Amyloidosis is a group of diseases in which protein is deposited in specific organs (localized amyloidosis) or throughout the body (systemic amyloidosis). Amyloidosis may be either primary (with no known cause) or secondary (caused by another disease, including some types of cancer). Generally, primary amyloidosis affects the nerves, skin, tongue, joints, heart, and liver; secondary amyloidosis often affects the spleen, kidneys, liver, and adrenal glands (National Cancer Institute, 2007).

To initiate the prior authorization process, it is necessary to complete and submit the Stem Cell Transplant Request for Coverage Form.

COVERAGE GUIDELINES

Autologous HSCT

Tufts Health Plan may authorize coverage of an autologous HSCT for the treatment of primary systemic amyloidosis (i.e., amyloid light-chain or AL) when all of the following criteria are met:

- Biopsy proven Amyloid
- Eastern Cooperative Oncology Group (ECOG) performance status 0-3 (refer to ECOG Performance Status)
- Single-organ involvement, or two-organ involvement with ECOG performance 0-1 (refer to ECOG Performance Status)
- Absence of Multiple Myeloma
- Cardiac interventricular septal thickness is less than or equal to 15 mm
- Left ventricular ejection fraction is greater than 55%
- Serum creatinine is less than or equal to 2.0 mg/dl
Hematopoietic Stem Cell Transplantation (HSCT) for the Treatment of Amyloidosis

- Adequate pulmonary function with normal oxygen saturation on room air
- Adequate liver function as defined as total bilirubin less than 2.0 mg/dl and transaminases less than two times normal

**Allogeneic HSCT**
Tufts Health Plan does not cover allogeneic HSCT for amyloidosis.

**Non-myeloablative Allogeneic HSCT**
Tufts Health Plan does not cover non-myeloablative allogeneic HSCT for amyloidosis.

**LIMITATIONS**
None

**CODES**
The following HCPCS/CPT codes require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>38204</td>
<td>Management of recipient hematopoietic progenitor cell donor search and cell acquisition</td>
</tr>
<tr>
<td>38205</td>
<td>Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic</td>
</tr>
<tr>
<td>38206</td>
<td>Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous</td>
</tr>
<tr>
<td>38207</td>
<td>Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage</td>
</tr>
<tr>
<td>38230</td>
<td>Bone marrow harvesting for transplantation</td>
</tr>
<tr>
<td>38240</td>
<td>Bone marrow or blood-derived peripheral stem transplantation; allogeneic</td>
</tr>
<tr>
<td>38241</td>
<td>Bone marrow or blood-derived peripheral stem cell transplantation; autologous</td>
</tr>
<tr>
<td>38242</td>
<td>Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions</td>
</tr>
<tr>
<td>38243</td>
<td>Hematopoietic progenitor cell (HPC); HPC boost</td>
</tr>
<tr>
<td>S2140</td>
<td>Cord blood harvesting for transplantation, allogeneic</td>
</tr>
<tr>
<td>S2142</td>
<td>Cord blood-derived stem-cell transplantation, allogeneic</td>
</tr>
<tr>
<td>S2150</td>
<td>Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre-and post-transplant care in the global definition</td>
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**REFERENCES**

**APPROVAL HISTORY**
November 2006: Reviewed by the Clinical Coverage Criteria Committee.

Subsequent endorsement date(s) and changes made:
- March 16, 2007: New Format
- April 25, 2008: Reviewed and renewed without changes
- April 6, 2009: Reviewed and renewed without changes
- November 1, 2009: Reviewed by Medical Affairs Medical Policy Committee, no changes
- November 2010: Reviewed by MSPAC, no changes
- December 14, 2011: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), no changes
- December 12, 2012: Reviewed by IMPAC, coding updated
- December 11, 2013: Reviewed by IMPAC, renewed without changes
December 10, 2014: Reviewed by IMPAC, renewed without changes
February 23, 2015: Administrative update.
September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
October 14, 2015: Reviewed by IMPAC, renewed without changes
July 20, 2016: Reviewed by IMPAC, renewed without changes
November 9, 2016: Reviewed by IMPAC, renewed without changes
November 23, 2016: Contact information updated
April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
September 18, 2017: Administrative update
December 13, 2017: Reviewed by IMPAC, renewed without changes

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to the fully insured Commercial and Medicaid products when Tufts Health Plan conducts utilization review unless otherwise noted in this guideline or in the Member’s benefit document, and may apply to Tufts Health Unify to the same extent as Tufts Health Together. This guideline does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Applicable state or federal mandates or other requirements will take precedence. For CareLink™ Members, Cigna conducts utilization review so Cigna’s medical necessity guidelines, rather than these guidelines, will apply.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of these guidelines is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

Provider Services

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