Medical Necessity Guidelines: Tumor Treating Fields (TTF)

Effective: October 21, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:

COMMERCIAL Products

☒ Tufts Health Plan Commercial products; Fax: 617.972.9409

☒ Tufts Health Freedom Plan products; Fax: 617.972.9409

- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055

☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055

☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404

☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products

- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

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

Glioblastomas (grade IV astrocytomas) are one of the most common types of primary malignant brain tumors in adults. These tumors develop from glial cells in the brain and are usually highly malignant (cancerous) because the cells reproduce quickly and they are supported by a large network of blood vessels. The overall prognosis is poor, even with the best standard of care. With optimal treatment, the median survival time is approximately 10 to 14 months. Only approximately one third of patients survive for one year following diagnosis of GBM, and fewer than 5% live beyond 5 years. Virtually all patients with newly diagnosed GBM relapse despite best available treatment. Patients with recurrent GBM have a median survival time of five to seven months.

Tumor treating fields (TTF) therapy is administered via a portable medical device that generates low-intensity alternating electric fields, called tumor treating fields. TTF aims to treat GBM by disrupting the rapid cell division exhibited by malignant cells.

CLINICAL COVERAGE CRITERIA

Tufts Health Plan may authorize coverage of TTF therapy for the following indications:

- In combination with temozolomide (TMZ) in adult patients (22 years of age and older) with histologically-or radiologically-confirmed newly-diagnosed glioblastoma following surgery and radiation with concomitant chemotherapy
- As monotherapy in adult patients (22 years of age and older) with histologically-or radiologically-confirmed recurrent glioblastoma (GBM) after surgical and radiation options have been exhausted.

Note: Authorization will be in 3-month increments.

LIMITATIONS

Tufts Health Plan will not cover TTF therapy for the treatment of any condition not outlined above.

CODES

The following HCPCS code(s) require prior authorization:

Table 1: HCPCS Codes

CPT Code	Description
E0766	Electrical stimulation device used for cancer treatment, includes all accessories, any type
A4555	Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only

Table 3: ICD-10 Codes

ICD-10 Code	Description
C71.0	Malignant neoplasm of cerebrum, except lobes and ventricles
C71.1	Malignant neoplasm of frontal lobe
C71.2	Malignant neoplasm of temporal lobe
C71.3	Malignant neoplasm of parietal lobe
C71.4	Malignant neoplasm of occipital lobe
C71.5	Malignant neoplasm of cerebral ventricle
C71.6	Malignant neoplasm of cerebellum
C71.7	Malignant neoplasm of brain stem
C71.8	Malignant neoplasm of overlapping sites of brain
C71.9	Malignant neoplasm of brain, unspecified

REFERENCES

1. American Brain Tumor Association. abta.org. Accessed August 5, 2016.
2. Hayes, Winifred S., Directory Report. Novocure (Tumor Treating Fields). March 3, 2016. Available at hayesinc.com. Accessed July 20, 2016.
3. United States Food and Drug Administration. Summary of Safety and Effectiveness Data, Novo TTF-100A System (Premarket Approval Number P100034). Available at fda.gov. Accessed August 5, 2016.
4. Stupp, R., et al. Effect of Tumor-Treating Fields Plus Maintenance Temozolomide vs Maintenance Temozolomide Alone on Survival in Patients With Glioblastoma: A Randomized Clinical Trial. JAMA. 2017 Dec 19;318(23):2306-2316. doi: 10.1001/jama.2017.18718. Last accessed April, 2019.

APPROVAL HISTORY

August 10, 2016: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC), effective January 1, 2017.

Subsequent endorsement date(s) and changes made:

- November 9, 2016: Reviewed by IMPAC, renewed without changes
- February 8, 2017: Reviewed by IMPAC, renewed without changes
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- December 13, 2017: Reviewed by IMPAC, renewed without changes
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- April 17, 2019: Reviewed by IMPAC, added approved indication and note under Clinical Coverage Criteria
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 4, 2020: Fax number for Unify updated

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.

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.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline 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.