PREMERA BLUE CROSS

MEDICAL POLICY – 8.01.17

Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma and POEMS Syndrome

BCBSA Ref. Policy:	8.01.17
Effective Date:	April 1, 2019
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RELATED MEDICAL POLICIES:

2.01.91	Peroral Endoscopic Myotomy for Treatment of Esophageal Achalasia
7.01.50	Placental and Umbilical Cord Blood as a Source of Stem Cells

Select a hyperlink below to be directed to that section.

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Plasma cells are a special type of white blood cell. They are made in the bone marrow, and they make antibodies to fight viral and bacterial infections. Multiple myeloma and POEMS syndrome are two types of bone marrow cancer that affect the plasma cells. These cancers may be treated with various medications and chemotherapy. Sometimes a person may be given a very high dose of chemotherapy followed by a hematopoietic cell transplant. This policy describes when a hematopoietic cell transplant may be medically necessary as part of the treatment of multiple myeloma and POEMS syndrome.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Transplant	Medical Necessity
Multiple Myeloma	
A single or second (salvage) autologous hematopoietic cell transplantation	**A single or second (salvage) autologous hematopoietic cell transplantation may be considered medically necessary to treat multiple myeloma.**
Tandem autologous hematopoietic cell transplantation	**Tandem autologous hematopoietic cell transplantation may be considered medically necessary to treat multiple myeloma in patients who fail to achieve at least a near-complete or very good partial response after the first transplant in the tandem sequence.** **Tandem transplantation with an initial round of autologous hematopoietic cell transplantation followed by a non-marrow-ablative conditioning regimen and allogeneic hematopoietic cell transplantation (ie, reduced-intensity conditioning transplant) may be considered medically necessary to treat newly diagnosed multiple myeloma patients.**
POEMS Syndrome	
Autologous hematopoietic cell transplantation	**Autologous hematopoietic cell transplantation may be considered medically necessary to treat disseminated POEMS syndrome (see Additional Information below).**

Transplant	Investigational
Multiple Myeloma	
Allogeneic hematopoietic cell transplantation	**Allogeneic hematopoietic cell transplantation, myeloablative or nonmyeloablative, as upfront therapy of newly diagnosed multiple myeloma or as salvage therapy, is considered investigational.**
POEMS Syndrome	
Allogeneic and tandem hematopoietic cell transplantation	**Allogeneic and tandem hematopoietic cell transplantation are considered investigational to treat POEMS syndrome.**

Additional Information
• The International Working Group on Myeloma has updated the European Group for Blood and

Additional Information

Marrow Transplant criteria to describe a complete response to multiple myeloma therapy. The criteria include negative immunofixation on the serum and urine; disappearance of soft tissue plasmacytomas; and 5% or fewer plasma cells in bone marrow aspiration.

- Patients with disseminated POEMS syndrome may have diffuse sclerotic lesions or disseminated bone marrow involvement.

Documentation Requirements

The patient's medical records submitted for review should document that medical necessity criteria are met. The record should include clinical documentation of:

- Diagnosis/condition
- History and physical examination documenting the severity of the condition
- Prior treatment (if any) patient has received

Coding

Code	Description
CPT	
38204	Management of recipient hematopoietic progenitor cell donor search and cell acquisition
38205	Blood derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous
38207	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage
38208	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor
38209	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor
38210	Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion
38211	Transplant preparation of hematopoietic progenitor cells; tumor cell depletion
38212	Transplant preparation of hematopoietic progenitor cells; red blood cell removal

Code	Description
38213	Transplant preparation of hematopoietic progenitor cells; platelet depletion
38214	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion
38215	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer
38230	Bone marrow harvesting for transplantation; allogeneic
38232	Bone marrow harvesting for transplantation; autologous
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor
38241	Hematopoietic progenitor cell (HPC); autologous transplantation
38242	Allogeneic lymphocyte infusions
HCPCS	
S2140	Cord blood harvesting for transplantation, allogeneic
S2142	Cord blood derived stem cell transplantation, allogeneic
S2150	Bone marrow or blood-derived stem cell (peripherial 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

Related Information

N/A

Evidence Review

Description

Multiple myeloma (MM) is a systemic malignancy of plasma cells that represents approximately 10% of all hematologic cancers. POEMS syndrome, characterized by polyneuropathy, organomegaly, endocrinopathy, M protein, and skin changes, is a rare, paraneoplastic disorder secondary to a plasma cell dyscrasia. Plasma cell dyscrasias are treatable but rarely curable. In some cases, hematopoietic cell transplantation (HCT) is considered as therapy.

Background

Multiple Myeloma

MM is a systemic malignancy of plasma cells that represents approximately 10% of all hematologic cancers. It is treatable but rarely curable. At diagnosis, most patients have generalized disease, and the selection of treatment is influenced by patient age, general health, prior therapy, and the presence of disease complications.[1-3]

The disease is staged by estimating tumor mass, based on various clinical parameters such as hemoglobin, serum calcium, number of lytic bone lesions, and the presence or absence of renal failure. MM usually evolves from an asymptomatic premalignant stage (termed monoclonal gammopathy of undetermined significance). Treatment is usually reserved for patients with symptomatic disease (usually progressive myeloma), whereas asymptomatic patients are observed because there is little evidence that early treatment of asymptomatic MM prolongs survival when compared with therapy delivered at the time of symptoms or end-organ damage.[1,2] In some patients, an intermediate asymptomatic but more advanced premalignant stage is recognized and referred to as smoldering MM. The overall risk of disease progression from smoldering to symptomatic MM is 10% per year for the first 5 years, approximately 3% per year for the next 5 years, and 1% for the next 10 years.[1,2]

POEMS Syndrome

POEMS syndrome (also known as osteosclerotic myeloma, Crow-Fukase syndrome, or Takatsuki syndrome) is a rare, paraneoplastic disorder secondary to a plasma-cell dyscrasia.[4,5] This complex, multiorgan disease was first described in 1938, but the acronym POEMS was coined in 1980, reflecting hallmark characteristics of the syndrome: polyneuropathy, organomegaly, endocrinopathy, M protein, and skin changes.[6] No single test establishes the presence of POEMS syndrome. Its pathogenesis is undefined, although some evidence has suggested it is mediated

by an imbalance of proinflammatory cytokines including interleukin (IL)-1β, IL-6, and tumor necrosis factor-α; vascular endothelial growth factor may also be involved.[5,7] However, specific criteria have been established, and the syndrome may entail other findings in the constellation of signs and symptoms, as shown in **Table 1**. Both major criteria and at least 1 of the minor criteria are necessary for diagnosis.[7]

Table 1: Criteria and Associations for POEMS Syndrome

Major Criteria	Minor Criteria	Known Associations	Possible Associations
Polyneuropathy			
	Sclerotic bone lesions	Clubbing	Pulmonary hypertension
Monoclonal plasma-proliferative disorder			
	Castleman disease	Weight loss	Restrictive lung disease
	Organomegaly (splenomegaly, hepatomegaly, or lymphadenopathy)	Thrombocytosis	Thrombotic diatheses
	Edema (edema, pleural effusion, or ascites)	Polycythemia	Arthralgias
	Endocrinopathy (adrenal, thyroid, pituitary, gonadal, parathyroid, pancreatic)	Hyperhidrosis	Cardiomyopathy (systolic dysfunction)
	Skin changes (hyperpigmentation, hypertrichosis, plethora, hemangiomata, white nails)		Fever
	Papilledema		Low vitamin B_{12} values
			Diarrhea

The prevalence of POEMS syndrome is unclear. A national survey in Japan showed a prevalence of about 0.3 per 100,000.[8] Other large series had been described in the United States[5,7,9] and India.[10] In general, patients with POEMS have a superior overall survival compared with that of MM (nearly 14 years in a large series).[7] However, given the rarity of POEMS, no randomized controlled trials of therapies have been reported.[11] Numerous approaches have included ionizing radiation, plasmapheresis, intravenous immunoglobulin, interferon-α, corticosteroids, alkylating agents, azathioprine, tamoxifen, transretinoic acid, and high-dose chemotherapy with autologous hematopoietic cell transplantation (HCT)support.[5,7] Optimal treatment involves eliminating the plasma cell clone (eg, by surgical excision or local radiotherapy for an isolated plasmacytoma), or systemic chemotherapy in patients with disseminated disease (eg, medullary

disease or multiple plasmacytomas). Given the underlying plasma cell dyscrasia of POEMS, newer approaches to MM, including bortezomib, lenalidomide, and thalidomide, are also under investigation.[5,12]

HCT is a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone-marrow-toxic doses of cytotoxic drugs with or without whole body radiotherapy. Hematopoietic stem cells may be obtained from the transplant recipient (autologous HCT) or from a donor (allogeneic HCT [allo-HCT]). They can be harvested from bone marrow, peripheral blood, or umbilical cord blood shortly after delivery of neonates. Although cord blood is an allogeneic source, the stem cells in it are antigenically "naive" and thus are associated with a lower incidence of rejection or graft-versus-host disease. Cord blood is discussed in greater detail in a separate medical policy (see **Related Policies**).

Immunologic compatibility between infused hematopoietic stem cells and the recipient is not an issue in autologous HCT. However, immunologic compatibility between donor and patient is a critical factor for achieving a good outcome of allo-HCT. Compatibility is established by typing of human leukocyte antigen (HLA) using cellular, serologic, or molecular techniques. HLA refers to the tissue type expressed at the HLA-A, -B, and -DR (antigen-D related) loci on each arm of chromosome 6. Depending on the disease being treated, an acceptable donor will match the patient at all or most of the HLA loci (except umbilical cord blood).

Conditioning for HCT

Conventional Conditioning

The conventional ("classical") practice of allo-HCT involves administration of cytotoxic agents (eg, cyclophosphamide, busulfan) with or without total body irradiation at doses sufficient to destroy endogenous hematopoietic capability in the recipient. The beneficial treatment effect in this procedure is due to a combination of initial eradication of malignant cells and subsequent graft-versus-malignancy effect mediated by non-self-immunologic effector cells that develop after engraftment of allogeneic stem cells within the patient's bone marrow space. While the slower graft-versus-malignancy effect is considered to be the potentially curative component, it may be overwhelmed by extant disease without the use of pretransplant conditioning. However, intense conditioning regimens are limited to patients who are sufficiently fit medically to tolerate substantial adverse effects that include pre-engraftment opportunistic infections secondary to loss of endogenous bone marrow function and organ damage and failure caused by the cytotoxic drugs. Furthermore, in any allo-HCT, immunosuppressant drugs are required to

minimize graft rejection and graft-versus-host disease, which also increases susceptibility of the patient to opportunistic infections.

The success of autologous HCT is predicated on the ability of cytotoxic chemotherapy with or without radiation to eradicate cancerous cells from the blood and bone marrow. This permits subsequent engraftment and repopulation of bone marrow space with presumably normal hematopoietic cells obtained from the patient before undergoing bone marrow ablation. As a consequence, autologous HCT is typically performed as consolidation therapy when the patient's disease is in complete remission. Patients who undergo autologous HCT are susceptible to chemotherapy-related toxicities and opportunistic infections before engraftment, but not graft-versus-host disease.

Reduced-Intensity Conditioning Allo-HCT

Reduced-intensity conditioning (RIC) refers to the pretransplant use of lower doses or less-intense regimens of cytotoxic drugs or radiation than are used in traditional full-dose myeloablative conditioning treatments. The goal of RIC is to reduce disease burden and to minimize as much as possible associated treatment-related morbidity and non-relapse mortality in the period during which the beneficial graft-versus-malignancy effect of allogeneic transplantation develops. Although the definition of RIC remains arbitrary, with numerous versions employed, all seek to balance the competing effects of non-relapse mortality and relapse due to residual disease. RIC regimens can be viewed as a continuum in effects, from nearly totally myeloablative to minimally myeloablative with lymphoablation, with intensity tailored to specific diseases and patient condition. Patients who undergo RIC with allo-HCT initially demonstrate donor cell engraftment and bone marrow mixed chimerism. Most will subsequently convert to full-donor chimerism, which may be supplemented with donor lymphocyte infusions to eradicate residual malignant cells.

For our purposes, the term reduced-intensity conditioning will refer to all conditioning regimens intended to be non-myeloablative, as opposed to fully myeloablative (traditional) regimens.

MM Treatment Overview

In the prechemotherapy era, the median survival for a patient diagnosed with MM was approximately 7 months. After the introduction of chemotherapy (eg, the alkylating agent melphalan in the 1960s), prognosis improved, with a median survival of 24 to 30 months and a 10-year survival of 3%. In a large group of patients with newly diagnosed MM, there was no

difference in overall survival reported during a 24-year period from 1971-1994, with a trend toward improvement during 1995-2000, and a statistically significant benefit in overall survival during 2001-2006.[2] These data suggested that autologous HCT was responsible for the trends during 1994-2000, while novel agents have contributed to the improvement since 2001.[2]

The introduction of novel agents and better prognostic indicators has been the major advances in the treatment of this disease.[13,14] Novel agents such as the proteasome inhibitor bortezomib and the immunomodulatory derivatives thalidomide and lenalidomide first showed efficacy in relapsed and refractory myeloma and now have been integrated into first-line regimens.[13-15] With the introduction of these novel treatments, it is now expected that most patients with MM will respond to initial therapy, and only a small minority will have refractory disease.[16]

Summary of Evidence

Newly Diagnosed Multiple Myeloma (MM)

For individuals who have newly diagnosed multiple myeloma who receive autologous hematopoietic cell transplantation (HCT) as initial treatment, the evidence includes several prospective, randomized controlled trials (RCTs) that compared conventional chemotherapy with high-dose chemotherapy plus autologous HCT. The relevant outcomes include overall survival and treatment-related morbidity. In general, the evidence has suggested overall survival rates are improved with autologous HCT compared with conventional chemotherapy in this setting. Limitations of the published evidence include patient heterogeneity, variability in treatment protocols, short follow-up periods, inconsistency in reporting important health outcomes, and inconsistency in reporting or collecting outcomes. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have newly diagnosed multiple myeloma who receive tandem autologous HCT, the evidence includes several RCTs. The relevant outcomes include overall survival and treatment-related morbidity. Compared with single autologous HCT, a number of RCTs have demonstrated tandem autologous HCT improved overall survival and recurrence-free survival in newly diagnosed multiple myeloma. The available RCTs compare RIC allo-HCT following a first autologous HCT with single or tandem autologous transplants. The RCTs were based on genetic randomization (ie, patients with a human leukocyte antigen-identical sibling who were offered an RIC allo-HCT following autologous HCT), whereas other patients underwent either 1 or 2 autologous transplants. Although the body of evidence has shown inconsistencies in terms of overall survival and disease-free survival rates, some studies have shown a survival benefit with tandem autologous HCT followed by RIC allo-HCT, although at the cost of higher transplant-

related mortality compared with conventional treatments. Factors across studies that may account for differing trial results include different study designs, nonuniform preparative regimens, different patient characteristics (including risk stratification), and criteria for advancing to a second transplant. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have newly diagnosed multiple myeloma who receive allo-HCT with initial or salvage treatment, the evidence includes nonrandomized studies. The relevant outcomes include overall survival and treatment-related morbidity. Studies have reported on patients with both myeloablative conditioning and RIC. Limitations of the published evidence include patient sample heterogeneity, variability in treatment protocols, short follow-up periods, inconsistency in reporting important health outcomes, and inconsistency in reporting or collecting outcomes. Nonmyeloablative allo-HCT as first-line therapy is associated with lower transplant-related mortality but a greater risk of relapse; convincing evidence is lacking that allo-HCT improves survival better than autologous HCT. The evidence is insufficient to determine the effects of the technology on health outcomes.

Relapsed or Refractory Multiple Myeloma

For individuals who have relapsed MM after failing an autologous HCT who receive autologous HCT, the evidence includes an RCT, a retrospective study, and a systematic review summarizing data from 4 series of patients who relapsed after a first autologous HCT, and a review summarizing recent studies on a second autologous HCT in relapsed myeloma. The relevant outcomes include overall survival and treatment-related morbidity. Despite some limitations of the published evidence, including patient sample heterogeneity, variability in treatment protocols, and short follow-up periods, the available trial evidence has suggested overall survival rates are improved with autologous HCT compared with conventional chemotherapy in this setting. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have refractory MM after failing the first HCT who receive tandem autologous HCT, the evidence includes 3 RCTs and a review. Relevant outcomes include overall survival and treatment-related morbidity. The evidence has shown tandem autologous HCT improves overall survival rates in this setting. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

POEMS Syndrome

For individuals who have POEMS syndrome who receive HCT, the evidence includes case reports and series. Relevant outcomes include overall survival and treatment-related morbidity. No RCTs of HCT of any type have been performed in patients with POEMS syndrome of any severity, nor is it likely such studies will be performed because of the rarity of this condition. Available case reports and series are subject to selection bias and are heterogeneous concerning treatment approaches and peritransplant support. However, for patients with disseminated POEMS syndrome, a chain of evidence and contextual factors related to the disease and MM would suggest improvement in health outcomes with autologous HCT. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in **Table 2**.

Table 2. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT01208662	A Randomized Phase III Study Comparing Conventional Dose Treatment Using a Combination of Lenalidomide, Bortezomib, and Dexamethasone (RVD) to High-dose Treatment With Peripheral Stem Cell Transplant in the Initial Management of Myeloma in Patients up to 65 Years of Age	660	Sep 2018
NCT02322320	Continued, Long-Term follow-Up and Lenalidomide Maintenance Therapy for Patients on BMT CTN 0702 (BMT CTN #Q07LT)	450	Dec 2018
NCT00177047	Autologous Transplantation for Multiple Myeloma	363	Jan 2020
NCT01109004	A Trial of Single Autologous Transplant With or Without Consolidation Therapy Versus Tandem Autologous Transplant With Lenalidomide Maintenance for Patients With Multiple Myeloma (BMT CTN 0702)	750	Mar 2018
NCT01191060	Randomized Study Comparing Conventional Dose Treatment Using a Combination of Lenalidomide,	700	Sep 2020

NCT No.	Trial Name	Planned Enrollment	Completion Date
	Bortezomib and Dexamethasone to High-Dose Treatment With ASCT in the Initial Management of Myeloma in Patients up to 65 Years of Age		
NCT01208766	A Randomized Phase III Study to Compare Bortezomib, Melphalan, Prednisone (VMP) With High Dose Melphalan Followed by Bortezomib, Lenalidomide, Dexamethasone (VRD) Consolidation and Lenalidomide Maintenance in Patients With Newly Diagnosed Multiple Myeloma	1500	Apr 2021
Unpublished			
NCT00998270	Autologous Bone Marrow Transplantation (BMT) Compared With Allogeneic BMT in Multiple Myeloma	185	Oct 2017 (unknown)

NCT: national clinical trial.

Clinical Input from Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2017 Input

In response to requests, input was received from 1 specialty medical society, 1 academic medical center, and 2 Blue Distinction Centers for Transplant while this policy was under review in 2017. There was consensus that allogeneic hematopoietic cell transplantation (HCT) is investigational for newly diagnosed multiple myeloma and as salvage therapy after primary graft failure and for primary progressive disease.

2013 Input

In response to requests, input was received from 3 academic medical centers and 6 Blue Distinction Centers for Transplant while this policy was under review in 2013. There was near-

consensus that autologous HCT is medically necessary for POEMS syndrome, and near-consensus that allogeneic and tandem HCT are investigational for POEMS syndrome.

2010 Input

In response to requests, input was received from 2 academic medical centers while this policy was under review in 2010. One reviewer agreed with the current policy statement related to tandem autologous HCT followed by reduced-intensity conditioning allogeneic HCT and the other disagreed. Those providing input agreed with the other policy statements. (The conclusion that allogeneic HCT is investigational for salvage therapy was a late addition to the policy and was not sent for clinical input.)

Practice Guidelines and Position Statements

American Society for Blood and Marrow Transplantation

The American Society for Blood and Marrow Transplantation (ASBMT) (2015) published evidence-based guidelines on the use of HCT in patients with multiple myeloma (MM).[63] ASBMT recognized that much of the evidence from randomized controlled trials summarized in the 2015 guidelines came from trials that predated the novel triple-therapy induction regimens. Furthermore, advances in supportive care and earlier disease detection have increasingly influenced decision making and allow individual tailoring of therapy. ASBMT guidelines did not address POEMS or other plasma cell dyscrasias besides MM.

The ASBMT, and 3 other groups (2015) published joint guidelines based on an expert consensus conference.[64] These guidelines contained the following recommendations for HCT as salvage therapy:

> … autologous HCT: (1) In transplantation-eligible patients relapsing after primary therapy that did NOT include an autologous HCT, high-dose therapy with HCT as part of salvage therapy should be considered standard; (2) High-dose therapy and autologous HCT should be considered appropriate therapy for any patients relapsing after primary therapy that includes an autologous HCT with initial remission duration of more than 18 months; (3) High-dose therapy and autologous HCT can be used as bridging strategy to allogeneic HCT; (4) The role of postsalvage HCT maintenance needs to be explored in the context of well-designed prospective trials that should include new agents, such as monoclonal antibodies, immune-modulating agents, and oral proteasome inhibitors; (5) Autologous HCT

consolidation should be explored as a strategy to develop novel conditioning regimens or post-HCT strategies in patients with short remission (less than 18 months remissions) after primary therapy and (6) Prospective randomized trials need to be performed to define the role of salvage autologous HCT in patients with MM [multiple myeloma] relapsing after primary therapy comparing to 'best non-HCT' therapy.

Regarding allogeneic HCT… (1) Allogeneic HCT should be considered appropriate therapy for any eligible patient with early relapse (less than 24 months) after primary therapy that included an autologous HCT and/or with high-risk features (ie, cytogenetics, extramedullary disease, plasma cell leukemia, or high lactate dehydrogenase); (2) Allogeneic HCT should be performed in the context of a clinical trial if possible; (3) The role of post allogeneic HCT maintenance therapy needs to be explored in the context of well-designed prospective trials; and (4) Prospective randomized trials need to be performed to define the role of salvage allogeneic HCT in patients with MM relapsing after primary therapy.

International Myeloma Working Group

The 2010 conclusions and recommendations of the International Myeloma Working Group consensus statement on the current status of allogeneic HCT (allo-HCT) for MM are as follows: Myeloablative allogeneic HCT may cure a minority of patients but is associated with a high transplant-related mortality, but could be evaluated in well-designed prospective clinical trials.[65] Nonmyeloablative allo-HCT as first-line therapy is associated with lower transplant-related mortality but a greater risk of relapse, and convincing evidence is lacking that allo-HCT improves survival compared with autologous HCT.

National Comprehensive Cancer Network

Autologous HCT

The National Comprehensive Cancer Network (NCCN) guidelines (v.3.2018) consider autologous HCT a category 1 recommendation as follow-up to induction therapy for newly diagnosed MM and as a category 1 recommendation for relapsed or progressive disease if the patient is considered a transplant candidate.[66]

Tandem HCT

The NCCN recommends collecting enough stem cells for 2 transplants in all eligible patients.[66]

Allo-HCT

The NCCN recommends the following for allo-HCT: "Allogeneic stem cell transplant may include nonmyeloablative (mini) following autologous stem cell transplant or fully myeloablative, preferably on a clinical trial. Current data do not support miniallografting alone" (category 2A).[66]

POEMS Syndrome

The NCCN guidelines do not address the treatment of POEMS syndrome.[66]

Medicare National Coverage

Medicare has the following national coverage determination for the use of HCT for MM.[67]

"Effective … January … 2016, allogeneic HSCT [hematopoietic stem cell transplantation] for multiple myeloma is covered by Medicare only for beneficiaries with Durie-Salmon Stage II or III multiple myeloma, or International Staging System (ISS) Stage II or Stage III multiple myeloma, and participating in an approved prospective clinical study that meets the criteria below. There must be appropriate statistical techniques to control for selection bias and confounding by age, duration of diagnosis, disease classification, International Myeloma Working Group (IMWG) classification, ISS stage, comorbid conditions, type of preparative/conditioning regimen, graft vs. host disease (GVHD) prophylaxis, donor type and cell source.

A prospective clinical study seeking Medicare coverage for allogeneic HSCT for multiple myeloma pursuant to CED must address the following question:

Compared to patients who do not receive allogeneic HSCT, do Medicare beneficiaries with multiple myeloma who receive allogeneic HSCT have improved outcomes as indicated by:

- Graft vs. host disease (acute and chronic);
- Other transplant-related adverse events;
- Overall survival; and

- (optional) Quality of life?"

Regulatory Status

The U.S. Food and Drug Administration regulates human cells and tissues intended for implantation, transplantation, or infusion through the Center for Biologics Evaluation and Research, under Code of Federal Regulation title 21, parts 1270 and 1271. Hematopoietic stem cells are included in these regulations.

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History

Date	Comments
06/12/12	New policy, add to Therapy section. Policy replaces 8.01.507.
09/10/12	Update coding section – ICD-10 codes are now effective 10/01/2014.
11/15/12	Reviewed and recommended by OAP, November 2012.
02/01/13	Update Related Policies, change title of policy 8.01.21.
02/12/13	Update Related Policies, change title of policy 8.02.02.
03/20/13	The following codes were removed from the policy, as they were not suspending and just informational: HCPCS J9000-J9999 and Q0083 – Q0085.
07/25/13	Update Related Policies. Change title to 8.01.35, and add 8.01.520.
10/14/13	Replace policy. Policy title changed. Policy updated with literature search through mid-March 2013; no change in multiple myeloma policy statements. POEMS syndrome added, with a medically necessary statement for autologous HCT for disseminated disease; allogeneic and tandem HCT for POEMS are investigational. Reference numbers 1, 6-9, 43 were removed, references 3-11, 47 were added and all were renumbered.
11/20/13	Update Related Policies. Add 2.01.91, and removed 8.01.31 as it was archived.
02/27/14	Update Related Policies. Change title to 8.01.29 and 8.01.30.
03/21/14	Update Related Policies. Add 8.01.15 and delete 8.01.514.
04/18/14	Update Related Policies. Delete 8.01.20 and add 8.01.529.
06/24/14	Update Related Policies. Delete 8.01.42 and add 8.01.530
11/20/14	Annual Review. Policy updated with literature review through June 15, 2014; no change in policy statements. Reference numbers 2 and 3 were removed; numbers 1, 32, 42, 47, 48, and 50 were added. ICD-9 and ICD-10 diagnosis and procedure codes removed; they do not related to adjudication of the policy.
10/13/15	Annual Review. Policy updated with literature review through July 14, 2015; references 2-3 were removed, references 16, 32, and 54 were added. Policy statements unchanged. Coding update: CPT codes 38320-21 and 86812-16, 86821-22 removed; these are informational and not reviewed in the scope of this policy.
08/01/16	Annual Review, approved July 12, 2016. No changes to policy statement.
01/01/17	Interim Review, approved December 13, 2016. Policy paragraphs restructured and wording edited for more specific restrictions of HCST for POEMS to autologous transplant only and excluding allogeneic including RIC allogeneic, RIC autologous, and

Date	Comments
	tandem transplantations. HCT for myeloma clarified to explicitly require induction chemotherapy achieving partial response or better prior to HCT for initial treatment sequence. Remainder of policy statements unchanged.
04/01/17	Annual Review, approved March 14, 2017. Policy updated with literature review through July 13, 2016 and results of clinical input; references 21, 48, and 55 added; reference 59 updated. Policy statements became less restrictive in regards to treatment of multiple myeloma.
06/09/17	Coding update; updated description for CPT codes 38230, 38240, and 38241.
10/24/17	Policy moved to new format; no change to policy statements.
04/01/18	Annual Review, approved March 20, 2018. Policy updated with literature review through November 2017; references 21, 50-51, 53, 56-58, 61, and 68 added; reference 67 updated. Policy statements unchanged.
11/01/18	Minor update, removed 8.02.02 from related policies as it was archived.
01/15/19	Minor update, removed 12.04.97 from Related Policies as it was archived.
04/01/19	Annual Review, approved March 5, 2019. Policy updated with literature review through November 2018; reference 34 added. Policy statements unchanged.

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본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ (Lao):
ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ອາດຈະມີວັນທີສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-722-1471 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):
សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព ដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការជានាវ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញផ្លែ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-722-1471 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):
ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ਼ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-722-1471 (TTY: 800-842-5357).

فارسی (Farsi):
این اعلامیه حاوی اطلاعات مهم میباشد .این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق Premera Blue Cross باشد. به تاریخ های مهم در این اعلامیه توجه نمایید .شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید .شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-722-1471 (کاربران TTY تماس باشماره 800-842-5357) تماس برقرار نمایید.

Polskie (Polish):
To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross. Prosimy zwrócic uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-722-1471 (TTY: 800-842-5357).

Português (Portuguese):
Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 800-842-5357).

Română (Romanian):
Prezenta notificare conține informații importante. Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin Premera Blue Cross. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-722-1471 (TTY: 800-842-5357).

Русский (Russian):
Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

Fa'asamoa (Samoan):
Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'amatalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-722-1471 (TTY: 800-842-5357).

Español (Spanish):
Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog):
Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).

ไทย (Thai):
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-722-1471 (TTY: 800-842-5357)

Український (Ukrainian):
Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-722-1471 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 800-842-5357).