

MEDICAL POLICY – 8.01.30

Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia

BCBSA Ref. Policy: 8.01.30

Effective Date: June 1, 2018

Last Revised: May 3, 2018

Replaces: N/A

RELATED MEDICAL POLICIES:


7.01.50 Placental and Umbilical Cord Blood as a Source of Stem Cells

8.01.26 Hematopoietic Cell Transplantation for Acute Myeloid Leukemia

8.01.520 Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia

Select a hyperlink below to be directed to that section.

[POLICY CRITERIA](#) | [CODING](#) | [RELATED INFORMATION](#)[EVIDENCE REVIEW](#) | [REFERENCES](#) | [HISTORY](#)

 Clicking this icon returns you to the hyperlinks menu above.

Introduction

Chronic myeloid leukemia (CML) is a type of cancer that starts in certain blood-forming cells within the bone marrow. These blood-forming cells are called “hematopoietic” cells. When a person has CML, they make too many white blood cells. Different types of treatment have been used against CML, including chemotherapy and other medications. Another common type of treatment is a hematopoietic cell transplant. In a hematopoietic cell transplant, hematopoietic cells are taken from a donor’s bone marrow and are given to the person with CML, just like in a transfusion. It is hoped that these new cells will then settle into the bone marrow and start producing normal blood cells, and the person will no longer have CML.

When the hematopoietic cells are harvested from another person, it is called an allogeneic transplant. When the cells come from the patient himself, it is called an autologous cell transplant. This policy discusses when an allogeneic hematopoietic cell transplant would be medically necessary to treat CML.

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
Allogeneic hematopoietic cell transplantation (HCT)	<p>Allogeneic hematopoietic cell transplantation (HCT) using a myeloablative conditioning regimen may be considered medically necessary as a treatment of chronic myeloid leukemia.</p> <p>Allogeneic hematopoietic cell transplantation using a reduced-intensity conditioning regimen may be considered medically necessary as a treatment of chronic myeloid leukemia in patients who meet clinical criteria for an allogeneic HCT but who are not considered candidates for a myeloablative conditioning allogeneic HCT.</p>

Transplant	Investigational
Autologous HCT	Autologous HCT is investigational as a treatment of chronic myeloid leukemia.

Additional Information
<ul style="list-style-type: none"> Some patients for whom a conventional myeloablative allotransplant could be curative may be considered candidates for reduced-intensity conditioning allogeneic hematopoietic stem-cell transplantation (HCT). These include those patients whose age (typically >60 years) or comorbidities (eg, liver or kidney dysfunction, generalized debilitation, prior intensive chemotherapy, low Karnofsky Performance Status) preclude use of a standard myeloablative conditioning regimen. For patients who qualify for a myeloablative allogeneic HCT on the basis of clinical status, either a myeloablative or reduced-intensity conditioning regimen may be considered medically necessary.

Coding



Code	Description
CPT	
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 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 service; and the number of days of pre- and post-transplant care in the global definition

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

Benefit Application

The following considerations may supersede this policy:

- State mandates requiring coverage for autologous bone marrow transplantation offered as part of clinical trials of autologous bone marrow transplantation approved by the National Institutes of Health (NIH).
- Some plans may participate in voluntary programs offering coverage for patients participating in NIH-approved clinical trials of cancer chemotherapies, including autologous bone marrow transplantation.



- Some contracts or certificates of coverage may include specific conditions in which autologous bone marrow transplantation would be considered eligible for coverage.

Evidence Review

Description

Chronic myeloid leukemia (CML) is a hematopoietic stem cell disorder that is characterized by the presence of a chromosomal abnormality called the Philadelphia chromosome, which results from reciprocal translocation between the long arms of chromosomes 9 and 22. CML most often presents in a chronic phase from which it progresses to an accelerated and then a blast phase. Allogeneic hematopoietic cell transplantation (allo-HCT) is a treatment option for CML.

Background

Chronic Myeloid Leukemia

CML is a hematopoietic stem-cell disorder that is characterized by the presence of a chromosomal abnormality called the Philadelphia chromosome, which results from reciprocal translocation between the long arms of chromosomes 9 and 22. This cytogenetic change results in constitutive activation of BCR-ABL, a tyrosine kinase (TK) that stimulates unregulated cell proliferation, inhibition of apoptosis, genetic instability, and perturbation of the interactions between CML cells and the bone marrow stroma only in malignant cells. CML accounts for about 15% of newly diagnosed cases of leukemia in adults and occurs in about 1 to 2 cases per 100,000 adults.¹

The natural history of the disease consists of an initial (indolent) chronic phase, lasting a median of 3 years, which typically transforms into an accelerated phase, followed by a "blast crisis," which is usually the terminal event. Most patients present in chronic phase, often with nonspecific symptoms that are secondary to anemia and splenomegaly. CML is diagnosed based on the presence of the Philadelphia chromosome abnormality by routine cytogenetics, or by detection of abnormal BCR-ABL products by fluorescence in situ hybridization or molecular studies, in the setting of persistent unexplained leukocytosis. Conventional-dose chemotherapy regimens used for chronic-phase disease can induce multiple remissions and delay the onset of



blast crisis to a median of 4 to 6 years. However, successive remissions are usually shorter and more difficult to achieve than their predecessors.

Treatment

Historically, the only curative therapy for CML in blast phase has been allogeneic hematopoietic cell transplantation (allo-HCT), which was used more widely earlier in the disease process given the lack of other curative therapies for chronic phase CML as well as improved efficacy when used prior to blast phase. Prior to the current TKI (tyrosine kinase inhibitor) drug era therapies for chronic phase CML were limited to nonspecific agents including busulfan, hydroxyurea, and interferon- α .¹

Imatinib mesylate (Gleevec®), a selective inhibitor of the abnormal BCR-ABL TK protein, for example, among the initial treatments of choice for newly diagnosed CML. Imatinib and other TKIs can be highly effective in suppressing CML in most patients, and some patients can achieve complete molecular remissions unmaintained after several years of therapy. The overall survival (OS) of patients who present in chronic phase is greater than 95% at 2 years and 80% to 90% at 5 years.²

For CML, 2 other tyrosine kinase inhibitors (TKIs; dasatinib, nilotinib) have received marketing approval from the U.S. Food and Drug Administration (FDA) as front-line therapies or following failure or patient intolerance of imatinib. Recently two additional TKIs (bosutinib, ponatinib) have been approved for use in patients resistant or intolerant to prior therapy.

For patients who progress on imatinib, the therapeutic options include increasing the imatinib dose, changing to another TKI, or allo-HCT. Detection of BCR-ABL variants may be important in determining an alternative TKI; the presence of T315I mutation is associated with resistance to all TKIs except ponatinib and may indicate the need for allo-HCT or an experimental therapy. TKIs have been associated with long-term remissions; if progression occurs after exhausting TKI therapy, allo-HCT is generally indicated and offers the potential for cure.

Hematopoietic Cell Transplant

Hematopoietic cell transplantation (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 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). 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 (GVHD). Cord blood is discussed in greater detail in another 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 allogeneic HCT. Compatibility is established by typing of human leukocyte antigens (HLAs) using cellular, serologic, or molecular techniques. HLA refers to the tissue type expressed at the HLA A, B, and DR 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 (with the exception of umbilical cord blood).

Conditioning for HCT

The conventional (“classical”) practice of allogeneic 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 (GVM) effect that develops after engraftment of allogeneic stem cells within the patient’s bone marrow space. While the slower GVM 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 allogeneic HCT, immune suppressant drugs are required to minimize graft rejection and GVHD, which also increases susceptibility of the patient to opportunistic infections. The immune reactivity between donor T cells and malignant cells that is responsible for the GVM effect also leads to acute and chronic GVHD.

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 stem 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 GVHD.

RIC (Reduced Intensity Conditioning) for Allogeneic HCT

RIC refers to the pretransplant use of lower doses or less intense regimens of cytotoxic drugs or radiation than are used in conventional full-dose myeloablative conditioning treatments. The goal of RIC is to reduce disease burden but also to minimize as much as possible associated treatment-related morbidity and nonrelapse mortality (NRM) in the period during which the beneficial GVM effect of allogeneic transplantation develops. Although the definition of RIC remains arbitrary, with numerous versions employed, all seek to balance the competing effects of NRM 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 allogeneic 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 the purposes of this Policy, the term “reduced-intensity conditioning” will refer to all conditioning regimens intended to be nonmyeloablative, as opposed to fully myeloablative (conventional) regimens.

For CML, RIC regimens were initially used to extend the use of allogeneic HCT to the estimated 70% of CML patients who were ineligible for myeloablative conditioning regimens because of advanced age or comorbidities. The use of RIC and allogeneic HCT is of particular interest for treatment of CML given the relatively pronounced susceptibility of this malignancy to the graft versus leukemia (GVL) effect of allogeneic hematopoietic progenitor cells following their engraftment in the host.

Summary of Evidence

For individuals who have CML who receive allo-HCT, the evidence includes systematic reviews, randomized controlled trials, and multiple prospective and retrospective series. Relevant outcomes are overall survival, disease-specific survival, and treatment-related morbidity and mortality. The introduction of TKIs has significantly changed the clinical use of HCT for CML. TKIs have replaced HCT as initial therapy for patients with chronic phase CML. However, a proportion of cases fail to respond to TKIs, develops resistance to them, or cannot tolerate TKIs and proceed to allo-HCT. Also, allo-HCT represents the only potentially curative option for those patients in the accelerated or blast phase CML. Currently, available evidence has suggested that



TKI pretreatment does not lead to worse outcomes if HCT is needed. Myeloablative conditioning regimens before HCT are used in younger (<60 years) patients without significant comorbidities. However, for patients with more comorbidities and/or more advanced age for whom myeloablative conditioning regimens would be prohibitively high-risk, evidence has suggested that reasonable outcomes can be obtained after RIC allo-HCT. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have CML who receive autologous HCT, the evidence includes case series. Relevant outcomes are overall survival, disease-specific survival, and treatment-related morbidity and mortality. In the largest series (N=200 patients), median survival was 36 months for patients transplanted during an accelerated phase; median survival data were not available for patients transplanted in chronic phase. Controlled studies are needed to permit conclusions on the impact of autologous HCT on health outcomes in patients with CML. The evidence is insufficient to determine the effects of the technology on health outcomes.

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in [Table 1](#).

Table 1. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT02638467	Allogeneic Stem Cell Transplantation in Chronic Myeloid Leukemia Failing TKIs Therapy	20	Jun 2018
NCT00036738	Fludarabine Phosphate and Total-Body Irradiation Followed by Donor Peripheral Blood Stem Cell Transplant in Treating Patients with Acute Lymphoblastic Leukemia or Chronic Myelogenous Leukemia That Has Responded to Treatment with Imatinib Mesylate, Desatinib, or Nilotinib	30	Oct 2018
NCT00709592	Reduced Intensity Total Body Irradiation + Thymoglobulin Followed by Allogeneic PBSCT	42	Sep 2020

NCT: national clinical trial.



Practice Guidelines and Position Statements

National Comprehensive Cancer Network Guidelines

Current National Comprehensive Cancer Network (NCCN) guidelines (v.1.2017) recommend allogeneic hematopoietic cell transplantation (allo-HCT) as an alternative treatment only for high-risk settings or in patients with advanced-phase chronic myeloid leukemia (CML).²⁹

Relevant recommendations are:

- “Allogeneic HCT is no longer recommended as a first-line treatment option for CP [chronic phase] CML.”
- “Allogeneic HCT is an appropriate first-line treatment option for the very rare patients presenting with blast phase at diagnosis, patients with T315I and other BCR-ABL1 variants that are resistant to all TKIs [tyrosine kinase inhibitors], and for the rare patients intolerant to all TKIs.”
- “Evaluation for allogeneic HCT....is recommended for all patients with AP [accelerated phase] CML or BP [blast phase] CML”

NCCN guidelines state: “Nonmyeloablative allogeneic HCT [hematopoietic cell transplantation] is a well-tolerated treatment option for patients with a matched donor and the selection of patients is based on their age and the presence of comorbidities.”

Autologous HCT for CML is not addressed in the NCCN guidelines.

American Society for Blood and Marrow Transplantation

In 2015, guidelines by the American Society for Blood and Marrow Transplantation addressed indications for autologous and allogeneic HCT for CML.³⁰ Recommendations are listed in [Table 2](#).



Table 2. ASBMT Recommendations on Allogeneic and Autologous HCT for CML

Indications	Allogeneic HCT	Autologous HCT
Pediatric		
Chronic phase	C	N
Accelerated phase	C	N
Blast phase	C	N
Adult		
Chronic phase, TKI intolerant	C	N
Chronic phase, TKI refractory	C	N
Chronic phase 2+	S	N
Accelerated phase	S	N
Blast phase	S	N

ASBMT: American Society for Blood and Marrow Transplantation; C: Standard of care, clinical evidence available, CML: chronic myeloid leukemia; HCT: hematopoietic cell transplantation; N: Not generally recommended; S: standard of care; TKI: tyrosine kinase inhibitor.

European LeukemiaNet Guidelines

In 2013, European LeukemiaNet issued updated guidelines for the management of CML.³¹ These guidelines recommend the use of allogeneic HCT in the following situations:

- For chronic phase treatment:
 - Consider HCT as second-line therapy after failure of nilotinib or dasatinib as first-line therapy.
 - Recommend HCT in all eligible patients as third-line therapy after failure of or intolerance to 2 TKIs.
 - Consider HCT at any point if T315I variant.
- For accelerated or blast phase in newly-diagnosed, TKI-naïve patients:
 - Begin imatinib or dasatinib.



- Recommend HCT for all blast phase patients and for accelerated phase patients who do not achieve an optimal response
- For accelerated or blast phase as progression from chronic phase in TKI-pretreated patients: recommend HCT for all patients (after initiation of one of the TKIs that was not previously used or ponatinib in the case of T315I variants).

Medicare National Coverage

There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

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 (CFR) title 21, parts 1270 and 1271. Hematopoietic stem cells are included in these regulations.

References

1. Jabbour E, Kantarjian H. Chronic myeloid leukemia: 2014 update on diagnosis, monitoring, and management. *Am J Hematol*. May 2014;89(5):547-556. PMID 24729196
2. Pavlu J, Szydlo RM, Goldman JM, et al. Three decades of transplantation for chronic myeloid leukemia: what have we learned? *Blood*. Jan 20 2011;117(3):755-763. PMID 20966165
3. Gratwohl A, Pfirrmann M, Zander A, et al. Long-term outcome of patients with newly diagnosed chronic myeloid leukemia: a randomized comparison of stem cell transplantation with drug treatment. *Leukemia*. Mar 2016;30(3):562-569. PMID 26464170
4. Fernandez HF, Kharfan-Dabaja MA. Tyrosine kinase inhibitors and allogeneic hematopoietic cell transplantation for chronic myeloid leukemia: targeting both therapeutic modalities. *Cancer Control*. Apr 2009;16(2):153-157. PMID 19337201
5. Apperley JF. Managing the patient with chronic myeloid leukemia through and after allogeneic stem cell transplantation. *Hematology Am Soc Hematol Educ Program*. Nov 2006:226-232. PMID 17124065
6. Druker BJ, Guilhot F, O'Brien SG, et al. Five-year follow-up of patients receiving imatinib for chronic myeloid leukemia. *N Engl J Med*. Dec 7 2006;355(23):2408-2417. PMID 17151364
7. Kantarjian H, Shah NP, Hochhaus A, et al. Dasatinib versus imatinib in newly diagnosed chronic-phase chronic myeloid leukemia. *N Engl J Med*. Jun 17 2010;362(24):2260-2270. PMID 20525995



8. Saglio G, Kim DW, Issaragrisil S, et al. Nilotinib versus imatinib for newly diagnosed chronic myeloid leukemia. *N Engl J Med*. Jun 17 2010;362(24):2251-2259. PMID 20525993
9. Liu YC, Hsiao HH, Chang CS, et al. Outcome of allotransplants in patients with chronic-phase chronic myeloid leukemia following imatinib failure: prognosis revisited. *Anticancer Res*. Oct 2013;33(10):4663-4667. PMID 24123046
10. Xu L, Zhu H, Hu J, et al. Superiority of allogeneic hematopoietic stem cell transplantation to nilotinib and dasatinib for adult patients with chronic myelogenous leukemia in the accelerated phase. *Front Med*. Sep 2015;9(3):304-311. PMID 26100855
11. Zhang GF, Zhou M, Bao XB, et al. Imatinib mesylate versus allogeneic hematopoietic stem cell transplantation for patients with chronic myelogenous leukemia. *Asian Pac J Cancer Prev*. Nov 2016;17(9):4477-4481. PMID 27797264
12. Shen K, Liu Q, Sun J, et al. Prior exposure to imatinib does not impact outcome of allogeneic hematopoietic transplantation for chronic myeloid leukemia patients: a single-center experience in China. *Int J Clin Exp Med*. May 2015;8(2):2495-2505. PMID 25932195
13. Chamseddine AN, Willekens C, De Botton S, et al. Retrospective study of allogeneic hematopoietic stem cell transplantation in Philadelphia chromosome-positive leukemia: 25 years' experience at Gustave Roussy Cancer Campus. *Clin Lymphoma Myeloma Leuk*. Jun 2015;15 Suppl:S129-140. PMID 26297265
14. Nair AP, Barnett MJ, Broady RC, et al. Allogeneic hematopoietic stem cell transplantation is an effective salvage therapy for patients with chronic myeloid leukemia presenting with advanced disease or failing treatment with tyrosine kinase inhibitors. *Biol Blood Marrow Transplant*. Aug 2015;21(8):1437-1444. PMID 25865648
15. Piekarska A, Gil L, Prejzner W, et al. Pretransplantation use of the second-generation tyrosine kinase inhibitors has no negative impact on the HCT outcome. *Ann Hematol*. Nov 2015;94(11):1891-1897. PMID 26220759
16. Zhao Y, Luo Y, Shi J, et al. Second-generation tyrosine kinase inhibitors combined with stem cell transplantation in patients with imatinib-refractory chronic myeloid leukemia. *Am J Med Sci*. Jun 2014;347(6):439-445. PMID 24553398
17. Egan DN, Beppu L, Radich JP. Patients with Philadelphia-positive leukemia with BCR-ABL kinase mutations before allogeneic transplantation predominantly relapse with the same mutation. *Biol Blood Marrow Transplant*. Jan 2015;21(1):184-189. PMID 25300870
18. Chakrabarti S, Buyck HC. Reduced-intensity transplantation in the treatment of haematological malignancies: current status and future-prospects. *Curr Stem Cell Res Ther*. May 2007;2(2):163-188. PMID 18220901
19. Crawley C, Szydlo R, Lalancette M, et al. Outcomes of reduced-intensity transplantation for chronic myeloid leukemia: an analysis of prognostic factors from the Chronic Leukemia Working Party of the EBMT. *Blood*. Nov 1 2005;106(9):2969-2976. PMID 15998838
20. Szatrowski TP. Progenitor cell transplantation for chronic myelogenous leukemia. *Semin Oncol*. Feb 1999;26(1):62-66. PMID 10073562
21. Bhatia R, Verfaillie CM, Miller JS, et al. Autologous transplantation therapy for chronic myelogenous leukemia. *Blood*. Apr 15 1997;89(8):2623-2634. PMID 9108379
22. McGlave PB, De Fabritiis P, Deisseroth A, et al. Autologous transplants for chronic myelogenous leukaemia: results from eight transplant groups. *Lancet*. Jun 11 1994;343(8911):1486-1488. PMID 7911185
23. Podesta M, Piaggio G, Sessarego M, et al. Autografting with Ph-negative progenitors in patients at diagnosis of chronic myeloid leukemia induces a prolonged prevalence of Ph-negative hemopoiesis. *Exp Hematol*. Feb 2000;28(2):210-215. PMID 10706077
24. Meloni G, Capria S, Vignetti M, et al. Ten-year follow-up of a single center prospective trial of unmanipulated peripheral blood stem cell autograft and interferon-alpha in early phase chronic myeloid leukemia. *Haematologica*. Jun 2001;86(6):596-601. PMID 11418368
25. Boiron JM, Cahn JY, Meloni G, et al. Chronic myeloid leukemia in first chronic phase not responding to alpha-interferon: outcome and prognostic factors after autologous transplantation. *EBMT Working Party on Chronic Leukemias. Bone Marrow Transplant*. Aug 1999;24(3):259-264. PMID 10455363



26. McBride NC, Cavenagh JD, Newland AC, et al. Autologous transplantation with Philadelphia-negative progenitor cells for patients with chronic myeloid leukaemia (CML) failing to attain a cytogenetic response to alpha interferon. *Bone Marrow Transplant.* Dec 2000;26(11):1165-1172. PMID 11149726
27. Michallet M, Thiebaut A, Philip I, et al. Late autologous transplantation in chronic myelogenous leukemia with peripheral blood progenitor cells mobilized by G-CSF and interferon-alpha. *Leukemia.* Dec 2000;14(12):2064-2069. PMID 11187894
28. Pigneux A, Faberes C, Boiron JM, et al. Autologous stem cell transplantation in chronic myeloid leukemia: a single center experience. *Bone Marrow Transplant.* Aug 1999;24(3):265-270. PMID 10455364
29. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology: Chronic Myeloid Leukemia. Version 3.2018. https://www.nccn.org/professionals/physician_gls/pdf/cml.pdf Accessed May 2018.
30. Majhail NS, Farnia SH, Carpenter PA, et al. Indications for autologous and allogeneic hematopoietic cell transplantation: guidelines from the American Society for Blood and Marrow Transplantation. *Biol Blood Marrow Transplant.* Nov 2015;21(11):1863-1869. PMID 26256941
31. Baccarani M, Deininger MW, Rosti G, et al. European LeukemiaNet recommendations for the management of chronic myeloid leukemia: 2013. *Blood.* Aug 8 2013;122(6):872-884. PMID 23803709

History

Date	Comments
02/01/00	Add to Therapy Section - New Policy — replaces 8.01.15, original master policy on high-dose chemotherapy for miscellaneous malignancies. However, policy statement is unchanged.
01/14/03	Replace Policy - Policy updated, new references added; no change in policy statement.
06/17/03	Replace Policy - Update CPT codes only.
08/12/03	Replace Policy - Reviewed and recommended for adoption without any changes by Company Oncology Advisory Panel July 22, 2003.
10/12/04	Replace Policy - Policy reviewed with literature search; no change in policy statement. Approved by OAP 10/29/04, returning to MPC.
01/10/06	Replace Policy - Policy reviewed with literature search; no change to policy statement.
06/02/06	Disclaimer and Scope updates - No other changes.
11/14/06	Replace Policy - Policy reviewed and recommended by OAP 10/26/06 without changes.
10/09/07	Replace Policy - BCBSA updated; Policy reviewed with literature search; policy statement unchanged; new references added.
10/14/08	Replace Policy - Policy updated with literature search; no change to the policy statement. References added.
11/11/08	Replace Policy - Policy extensively updated with literature search. Policy statement updated to remove "HDC" and replaced with "SCT", this is reflected within the title and



Date	Comments
	body of the policy. Investigational statement added to include Autologous SCT as a treatment of chronic myelogenous leukemia. References added. Reviewed and recommended for approval by the Oncology Advisory Panel, February 21, 2008.
01/12/10	Replace Policy - Policy updated extensively with literature review. Policy statements revised to consider RIC allogeneic SCT as medically necessary in specific conditions. References added.
02/09/10	Code Update - New 2010 codes added.
08/09/11	Replace Policy – Policy updated with literature search; no change to policy statements. References 11-14 added; reference 23 updated. ICD-10 codes added to policy. Related Policy titles updated.
10/19/11	Related Policies updated; codes 38220 and 38221 removed.
02/14/12	Replace Policy – Policy updated with literature search; no change to policy statements. References 15-17 added. Code 38232 added; code 38204 listed as Medicare Status B, non-reimbursable.
06/20/12	Minor update: Related Policies updated; 8.01.17 replaced 8.01.507 effective June 12, 2012.
07/30/12	Update Related Policies titles for: 8.01.17, 8.01.22, 8.01.29, 8.01.31, and 8.01.514.
10/09/12	Update Coding Section – ICD-10 codes are now effective 10/01/2014.
02/13/13	Replace policy. A literature review through October 2012 did not prompt any changes to the rationale section. Clarifications added to the practice guidelines and position statements. No new references added. Policy statement unchanged. Update title to Related Policy 8.01.21.
03/20/13	The following codes were removed from the policy, as they were not suspending and just informational: CPT 38204, HCPCS J9000-J9999 and Q0083-Q0085.
07/25/13	Update Related Policies. Change title to 8.01.35.
09/30/13	Update Related Policies. Change title to 8.01.31.
12/06/13	Update Related Policies. Remove 8.01.31 as it was archived.
02/10/14	Replace policy. Deleted the word “treatment” from the title. Policy Guidelines reworded for readability. Rationale updated with literature search through November 8, 2013. Reference 13,26 updated, reference 27 added Policy statements unchanged.
03/21/14	Update Related Policies. Remove 8.01.514 as it was deleted.
04/18/14	Update Related Policies. Remove 8.01.20 and add 8.01.529.
06/24/14	Update Related Policies. Remove 8.01.35, and 8.01.42, then add 8.01.530 and 8.01.532.
12/03/14	Update Related Policies. Remove 8.01.17.
02/10/15	Annual Review. Policy updated with literature review through November 3, 2014. References 1 and 15-18 added. Policy statements unchanged. Clarification made to



Date	Comments
	wording in the Policy Guidelines section for improved readability; no change in intent. ICD-9 and ICD-10 diagnosis and procedure codes removed.
04/12/16	Annual Review. Policy updated with literature review through October 27, 2015; references 3, 8, 18, and 20-22 added. Policy statements unchanged.
11/04/16	Coding update. Removed codes that are transplant benefit related.
04/01/17	Annual Review, approved March 14, 2017. Policy updated with literature review through November 9, 2016; references 11 and 30 added. In title and policy statements, "stem" removed and "myelogenous" changed to "myeloid".
11/10/17	Policy moved to new format, no changes to policy statement.
06/01/18	Annual Review, approved May 3, 2018. Policy updated with literature review through December 2017; no reference added, reference 29 updated. Policy statements unchanged.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2018 Premera All Rights Reserved.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.



Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

አማርኛ (Amharic):

ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀዳሾች ሊኖሩ ይችላሉ። የጤና ሽፋንዎን ለመጠበቅና በአስፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና የለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መሰታ አለዎት። በስልክ ቁጥር 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):

يحتوي هذا الإشعار على معلومات هامة. قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تزيد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تاريخ معينه للحفاظ على تغطيتك الصحية أو المساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ 800-722-1471 (TTY: 800-842-5357)

中文 (Chinese):

本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357)。

Oromoo (Cushite):

Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Premera Blue Cross tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-722-1471 (TTY: 800-842-5357) tii bilbilaa.

Français (French):

Cet avis a d'importantes informations. Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross. Le présent avis peut contenir des dates clés. Vous devez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-722-1471 (TTY: 800-842-5357).

Kreyòl ayisyen (Creole):

Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resewva enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-722-1471 (TTY: 800-842-5357).

Deutsche (German):

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-722-1471 (TTY: 800-842-5357).

Hmoob (Hmong):

Tsawb ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsawb ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam hnuv ntawm Premera Blue Cross. Tej zaum muaj cov hnuv tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-722-1471 (TTY: 800-842-5357).

Iloko (Ilocano):

Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti aplikasyonyo wenno coverage babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-ato wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian):

Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-722-1471 (TTY: 800-842-5357).

日本語 (Japanese):

この通知には重要な情報が含まれています。この通知には、Premera Blue Cross の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-722-1471 (TTY: 800-842-5357)までお電話ください。

한국어 (Korean):

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. 귀하의 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하의 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 ຄວາມຄົມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ອາດຈະມີວັນທີ່ສໍາຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດໍາເນີນການຕາມກຳນົດ ເວລາສະເພາະເພື່ອຮັກສາຄວາມຄົມຄອງປະກັນສະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເວັ້ນເວີ້ ຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄດ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໃບທາ 800-722-1471 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):

សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរៀបចំរបស់អ្នកតាមរយៈ Premera Blue Cross ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ជាក់សមត្ថភាព ដល់កិច្ចការផ្ទៃក្នុងដូចជា ធានា ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងអនាគតរបស់អ្នក ឬប្រាក់ជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះ 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 ਨੋਟਿਸ ਨਵ ਖਾਸ ਤਾਰੀਖਾਂ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀਂ ਜਸਰਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾਂ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਕੱਠ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ ਤੋਂ ਪਹਿਲਾਂ ਢੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫਤ ਵਿੱਚ ਤੋਂ ਅਪਣੀ 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 (کلیران 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 zwrócić 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 dumneavoastră 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 provizorie 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'matalaga 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 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 ganiitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).

ไทย (Thai):

ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับกาการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือในภาษาของคุณโดยไม่มีค่าใช้จ่าย 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 страховального 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).