# Hematopoietic Cell Transplantation for Primary Amyloidosis

**BCBSA Ref. Policy:** 8.01.42

**Effective Date:** May 1, 2019  
**Last Revised:** April 18, 2019  
**Replaces:** 8.01.530

<table>
<thead>
<tr>
<th>RELATED MEDICAL POLICIES</th>
</tr>
</thead>
</table>
| 7.01.50                  | Placental and Umbilical Cord Blood as a Source of Stem Cells  
| 8.01.21                  | Allogeneic Hematopoietic Cell Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms  
| 8.01.22                  | Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias  
| 8.01.24                  | Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults  
| 8.01.25                  | Hematopoietic Cell Transplantation for Autoimmune Diseases  
| 8.01.29                  | Hematopoietic Cell Transplantation for Hodgkin Lymphoma  
| 8.01.511                 | Hematopoietic Cell Transplantation for Solid Tumors of Childhood  
| 8.01.531                 | Hematopoietic Cell Transplantation for Waldenström Macroglobulinemia  
| 10.01.518                | Clinical Trials

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## Introduction

Primary amyloidosis is a condition in which clumps of abnormal proteins build up in tissues and organs. Treatment may include a stem cell transplant using the patient’s own cells. Stem cells are collected from the patient’s blood and stored. After the patient receives high-dose chemotherapy, stem cells are given back to the patient. Using a person’s own stem cells is known as an autologous stem cell transplant. Using stem cells from a donor is called an allogeneic transplant. Using donor stem cells to treat primary amyloidosis is investigational (unproven) because there is not enough scientific evidence to show that it works for this condition.
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

<table>
<thead>
<tr>
<th>Service</th>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autologous hematopoietic cell transplantation</td>
<td>Autologous hematopoietic cell transplantation may be considered medically necessary to treat primary systemic (AL) amyloidosis.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Investigational</th>
</tr>
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<td>Allogeneic hematopoietic cell transplantation</td>
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</table>

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
- The severity of the condition and prognosis (to included prognostic index scores when applicable)

Coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>CPT 38230</td>
<td>Bone marrow harvesting for transplantation; allogeneic</td>
</tr>
<tr>
<td>38232</td>
<td>Bone marrow harvesting for transplantation; autologous</td>
</tr>
<tr>
<td>38240</td>
<td>Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>38241</td>
<td>Hematopoietic progenitor cell (HPC); autologous transplantation</td>
</tr>
<tr>
<td>38242</td>
<td>Allogeneic lymphocyte infusions</td>
</tr>
</tbody>
</table>

**HCPCS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>S2140</td>
<td>Cord blood harvesting for transplantation, allogeneic</td>
</tr>
<tr>
<td>S2142</td>
<td>Cord blood-derived stem-cell transplantation, allogeneic</td>
</tr>
<tr>
<td>S2150</td>
<td>Bone marrow or blood-derived stem-cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with out-patient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre- and post-transplant care or the global definition.</td>
</tr>
</tbody>
</table>

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**Related Information**

N/A

**Evidence Review**

**Description**

Hematopoietic cell transplantation (HCT) refers to the infusion of hematopoietic stem cells 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).
Background

Primary Systemic Amyloidosis

The primary amyloidoses comprise a group of diseases with an underlying clonal plasma cell dyscrasia. They are characterized by the extracellular deposition of pathologic, insoluble protein fibrils with a beta-pleated sheet configuration that exhibits a pathognomonic red-green birefringence when stained with Congo red dye and examined under polarized light. These diseases are classified by the type of amyloidogenic protein involved and by the distribution of amyloid deposits. In systemic amyloidosis, the unnatural protein is produced at a site that is remote from the site(s) of deposition, whereas in localized disease, the amyloid light chain protein is produced at the site of deposition. Primary or amyloid light chain amyloidosis, the most common type of systemic amyloidosis, has an incidence similar to that of Hodgkin lymphoma or chronic myelogenous leukemia, estimated at 5 to 12 people per million annually. The median age at diagnosis is 60 years. The amyloidogenic protein in primary amyloidosis is an immunoglobulin light chain or light-chain fragment produced by a clonal population of plasma cells in the bone marrow. While the plasma cell burden in primary amyloidosis is typically low, ranging from 5% to 10%, this disease also may occur in association with multiple myeloma in 10% to 15% of patients. Deposition of primary amyloidogenic proteins causes organ dysfunction, most frequently in the kidneys, heart, and liver, although the central nervous system and brain may be affected.

Treatment

Historically, this disease has had a poor prognosis, with a median survival from diagnosis of approximately 12 months, although outcomes have improved with combination chemotherapy using alkylating agents and autologous hematopoietic cell transplantation (HCT). Emerging approaches include the use of immunomodulating drugs (eg, thalidomide, lenalidomide) and the proteasome inhibitor bortezomib. Regardless of the approach, treatment of primary amyloidosis aims at rapidly reducing the production of amyloidogenic monoclonal light chains by suppressing the underlying plasma cell dyscrasia, with supportive care to decrease symptoms and maintain organ function. The therapeutic index of any chemotherapy regimen is a key consideration in the context of underlying organ dysfunction.
**Hematopoietic Cell Transplantation**

Hematopoietic cell transplantation (HCT) refers to the infusion of hematopoietic stem cells 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 [allo-] HCT). They can be harvested from bone marrow, peripheral blood, or umbilical cord blood. 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 a separate policy (see Related Policies).

**Autologous HCT**

Immunologic compatibility between infused hematopoietic stem cells and the recipient is not an issue in autologous HCT. 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 response. Patients who undergo autologous HCT are susceptible to chemotherapy-related toxicities and opportunistic infections before engraftment, but not graft-versus-host disease.

**Allogeneic HCT**

Immunologic compatibility between donor and patient is a critical factor for achieving a good outcome of allogeneic HCT. Compatibility is established by typing human leukocyte antigen (HLA) 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.

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 effect that develops 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 events 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 graft-versus-host disease, which also increases susceptibility of the patient to opportunistic infections.

**Reduced-Intensity Conditioning for Allogeneic 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 conventional 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 variable with numerous versions employed, all seek to balance the competing effects of nonrelapse 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 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.

**Summary of Evidence**

For individuals who have primary amyloidosis who receive autologous hematopoietic cell transplantation (HCT), the evidence includes a randomized controlled trial (RCT), nonrandomized comparative studies, and large case series. Relevant outcomes are overall survival, disease-specific survival, change in disease status, and treatment-related morbidity and mortality. Use of autologous HCT for primary amyloidosis rapidly eradicates the amyloid light chain produced by the clonal plasma cell populations, which is the proximal cause of pathology and subsequent death. This procedure has extended survival rates to a reported 77% at 5 years and 56% at 10
years in patients who respond to treatment. Complete response to treatment has been reported in 34% to 66% of patients, while transplant-related mortality rates have declined to less than 14% in current studies. Therefore, autologous HCT is an important treatment option for patients who are deemed eligible. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

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For individuals who have primary amyloidosis who receive allogeneic HCT, the evidence includes case reports. Relevant outcomes are overall survival, disease-specific survival, change in disease status, treatment-related morbidity and mortality. Evidence on the use of allogeneic HCT is sparse and shows high treatment-related mortality. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical input and national and international clinical guidelines support the use of autologous HCT as a treatment of amyloidosis. For primary amyloidosis, allo-HCT is not recommended. Thus, autologous HCT may be considered medically necessary for primary amyloidosis, and allo-HCT for primary amyloidosis is considered investigational.

Ongoing and Unpublished Clinical Trials

A search of ClinicalTrials.gov in December 2018 did not identify any ongoing or unpublished trials that would likely influence this review.
Clinical Input Received 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.

In response to requests, input was received from 5 academic medical centers, including 3 transplant centers, while this policy was under review in 2011. There was support for the policy statements on hematopoietic stem transplantation in the treatment of amyloidosis.

Practice Guidelines and Position Statements

American Society for Blood and Marrow Transplantation

The American Society for Blood and Marrow Transplantation (2015) issued guidelines on the indications for autologous and allogeneic hematopoietic cell transplantation (HCT). The American Society for Blood and Marrow Transplantation gave the rating of N (not generally recommended; neither evidence nor clinical practice support the routine use) for the use of allogeneic HCT for the treatment of primary amyloidosis in adults. The American Society for Blood and Marrow Transplantation gave a rating of C (standard of care; clinical evidence available) for the use of autologous HCT in the treatment of primary amyloidosis in adults.

British Committee for Standards in Haematology

The British Committee for Standards in Haematology developed guidelines on the management of light chain (primary) amyloidosis. Table 1 summarizes of the recommendations from the 2015 guidelines on high-dose melphalan and autologous stem cell transplantation and allogeneic transplantation as treatments of primary amyloidosis.
Table 1. Recommendations on Use of High-Dose Melphalan, HDM-ASCT, and Allogeneic Transplant to Treat Primary Amyloidosis

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>GOR</th>
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<tbody>
<tr>
<td>HDM-ASCT recommended as &quot;the preferred first line treatment for patients up to 65-70 years of age with estimated glomerular filtration rate (eGFR) &gt; 50 ml/min, low cardiac biomarkers, low level plasma cell infiltration in bone marrow at time of transplant and lacking the contraindications....&quot;</td>
<td>1c</td>
</tr>
<tr>
<td>HDM-ASCT recommended with any of the following: Cardiac amyloidosis with N-terminal pro-brain natriuretic peptide &gt; 590 pmol/l and/or troponin-T &gt; 0.06 ng/ml, severe autonomic neuropathy, significant gastrointestinal (GI) bleeding due to amyloid, ... recurrent amyloid related pleural effusions or poor Eastern Cooperative Oncology Group performance status (&gt; 2).&quot;</td>
<td>1c</td>
</tr>
<tr>
<td>&quot;HDM-ASCT may be a treatment for selected patients up to 65-70 years of age with relapsed/refractory disease or with early relapse of plasma cell dyscrasia after chemotherapy.&quot;</td>
<td>1c</td>
</tr>
<tr>
<td>&quot;Reduced intensity allogeneic transplantation is generally not recommended as an upfront treatment due to high treatment-related mortality (TRM). However, selected fitter younger patients with limited organ involvement who have a matched sibling donor may be considered following relapse of their disease.&quot;</td>
<td>1a</td>
</tr>
</tbody>
</table>

GOR: grade of recommendation; HDM-ASCT: high dose melphalan autologous stem cell transplantation.

**National Comprehensive Cancer Network**

The National Comprehensive Cancer Network guidelines on systemic light chain amyloidosis (v.1.2019) recommend assessing organ involvement based on amyloidosis consensus. Next patients should be evaluated for stem cell transplant candidacy. In patients eligible for stem cell transplant, stem cells may be collected, and transplant delayed for a later line of therapy. The dose of melphalan as part of stem cell transplantation can be adjusted based on factors such as age, presence/absence of cardiac involvement, and number of organs involved. In eligible patients, high-dose chemotherapy followed by autologous stem cell transplant has demonstrated higher response rates and improved overall survival compared with chemotherapy alone.

**International Workshops on Waldenström Macroglobulinaemia**

The International Workshops on Waldenström Macroglobulinaemia (2017) published guidelines on the treatment of several paraproteinaemic neuropathies, one of which is primary, or amyloid light chain, amyloidosis. First-line treatment for eligible patients includes an autologous cell
transplant preceded by a high-dose regimen combining rituximab with another agent such as purine analogue, bendamustine, or bortezomib.

**Medicare National Coverage**

The Centers for Medicare & Medicaid Services has determined that the evidence is adequate to conclude that, when recognized clinical risk factors are employed to select patients for transplantation, high-dose melphalan together with autologous stem cell transplantation can provide a net health benefit for Medicare beneficiaries of any age group with primary amyloidosis (110.23, formerly 110.8.1). This technique “is reasonable and necessary for beneficiaries of any age with primary amyloid light chain (AL)amyloidosis who meet the following criteria:

- amyloid deposition in 2 or fewer organs, and
- cardiac left ventricular ejection fraction (EF) of greater than 45%.”

In addition, autologous HCT “must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy ... and/or radiotherapy used to treat various malignancies.”

**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.

**References**


### History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/01/19</td>
<td>New policy, approved April 18, 2019. This policy replaces 8.01.530. Policy created with literature review through October 2018. Autologous hematopoietic cell transplantation may be considered medically necessary to treat primary systemic (AL) amyloidosis. Allogeneic hematopoietic cell transplantation is considered investigational to treat primary systemic AL.</td>
</tr>
</tbody>
</table>

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PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentinquines@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 S09F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

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Email AppealsDepartmentinquines@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 S09F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

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Kreyól ayisyen (Creole):

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Polski (Polish):
To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie praw do bezpłatnej pomocy w przypadku utraty kosztów. Wszyscy mają prawo do beneficjowania z tą usługą. Wszyscy mogą uzyskać informacje odnoszące się do swojego statusu podatkowego i możliwości korzystania z usług w ramach swojej polityki.

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