Hematopoietic Cell Transplantation in Hodgkin’s Lymphoma

Policy Title: Hematopoietic Cell Transplantation in Hodgkin’s Lymphoma
Policy Number: F.28
Primary Department: Medical Management
Affiliated Department(s): N/A
NCQA Standard: N/A
URAC Standard: N/A
Last Revision Date: 03/04/2016
Revision Dates: 01/23/2015; 03/04/2016
Effective Date: 03/27/2015
Next Review Date: 03/2017
Review Dates: 03/27/2015; 03/25/2016
Special Instructions Alert: N/A

State/Program | MI | IL | IA | Medicare | Medicaid | Commercial
---|---|---|---|---|---|---
SNP | SNP | SNP | SNP | SNP | TANF | Exchange
MA | MA | MA | MA | MA | SPD | Exchange
PDP | PDP | PDP | PDP | PDP | SCHIP | Exchange
SCHIP | SCHIP | SCHIP | SCHIP | SCHIP | SCHIP | SCHIP
TANF | TANF | TANF | TANF | TANF | SPD | SPD

Policy:
Hodgkin’s lymphoma (HL) is a malignancy which involves the lymph nodes and lymphatic system. There are two peaks in age of diagnosis as follows: between the ages of 15-30 and 55 and older. Based upon the WHO classification there are two types of HL: nodular lymphocyte predominant Hodgkin lymphoma (NLPHL) and classical Hodgkin lymphoma (CHL). The majority or 95% fall into the CHL category of which there are four subtypes: nodular sclerosis (NSCHL), mixed cellularity (MCCHL), lymphocyte depleted (LDCHL) and lymphocyte rich (LRCHL).

General Guidelines:
Criteria for Autologous Hematopoietic Cell Transplantation:
Meridian considers autologous hematopoietic cell transplantation medically necessary for the following members with:
- Early relapse (less than 12 months after treatment) or induction failure or
- Second relapse after conventional treatment for first relapse or
- Generalized systemic relapse even beyond 12 months.
The use of autologous HCT in high risk members with advanced disease in first remission is controversial and investigational.

Criteria for Allogeneic Hematopoietic Cell Transplantation:
Meridian considers allogeneic hematopoietic cell transplantation medically necessary for the treatment of members with relapsed HL (including members who have relapsed or have had persistent disease from an autologous hematopoietic cell transplant) or primary refractory HL.
Members who relapse following high-dose therapy and autologous HCT have treatment options of single agent chemotherapy, local irradiation, repeat autologous HCT, or reduced intensity (nonmyeloablative or “mini-transplant”) conditioning followed by allogeneic HCT. Nonmyeloablative allogeneic HSCT for any other indication is considered experimental and investigational.

Tandem transplants (sequential within 6 months) are experimental/investigational for the treatment of Hodgkin’s lymphoma because of insufficient evidence of it safety and effectiveness.

Also, as consideration for hematopoietic stem cell transplantation these guidelines must be met:

1. The National Comprehensive Cancer Network guidelines must be met (http://www.nccn.org/index.asp)
2. The member meets selection criteria requirements regarding organ function. The following values should be used: cardiac function (left ventricular ejection fraction equal or greater than 45%); pulmonary function [forced vital capacity (FVC)/forced expiratory volume in 1 second (FEV1)/diffusion capacity of the lung for carbon monoxide (DLCO) equal to or greater than 50 % predicted].
3. Emotional and psychiatric stability, including a strong family or alternative support network (documented by formal social work evaluation)
4. Ability to understand the risks of the procedures
5. Karnofsky performance score of 70% or greater or Southwestern Oncology Group (SWOG)/Eastern Cooperative Oncology Group (ECOG) score of 0 to 2
6. No active infection including but not limited to HIV, hepatitis B, hepatitis C, or potential oral sources
7. Absence of psychiatric disease that would interfere with the member’s ability to comply with the pre- or post-transplant therapeutic regimen

Additional Selection Criteria: No significant history of medical noncompliance as defined by Meridian Health Plan Policy I.07:

1. For members with a history of tobacco use, if the member fails or refuses to submit to monthly cotinine testing for the preceding 6 months prior to the transplant and while listed, or refuses to actively and continuously participate in an accepted smoking cessation program.
2. For members with a history of alcohol abuse, member fails or refuses to submit to testing for alcohol use. Absence of documentation showing member has not engaged in alcohol use for at least six months prior to transplant and monthly while listed.
3. For members with a history of illicit drug use, member fails or refuses to submit to testing for illegal drug use. Absence of documentation showing member has not engaged in illegal drug use for at least six months prior to transplant and monthly testing while listed.
4. Tobacco, Alcohol and Drug Addiction: Refusal or failure to participate in available addiction interventions for actively using members must be documented in non-compliance determinations.

* If substance abuse is identified, and if the disease is slow growing and transplant is not imperative and/or when other treatment is needed before transplantation, a referral should be made to an addiction medicine specialist and chemical dependency treatment is begun before transplantation is offered. For those patients who require HSCT immediately, consultation must be obtained with an addiction medicine specialist and/or psychiatrist with experience in addiction during the patient’s hospital stay. This collaboration can serve to address both the management of acute withdrawal, if needed, and institute psychotherapeutic, educational and medical modalities to begin the recovery process. The patient must agree to a referral for ongoing chemical dependency treatment should be made once the patient is stable enough, medically, to participate in an addiction recovery program.
5. Documentation of non-impactable social issues that substantially increase the risks of an adverse outcome of the medical therapy or transplant at issue
6. Severely Mentally Ill Adults and Severely Emotionally Disturbed Minors: Non-adherence to psychotropic medications or medical regimen in SMI or SED members for whom core symptoms include lack of insight into illness, must be assessed for adequacy of and engagement with psychosocial resource supports in Care Coordination prior to non-compliance determinations.
7. Developmental or Acquired Cognitive Impairment and Dementia: Psychosocial and guardianship support as well as reversibility of impairment must be assessed and documented prior to non-compliance determinations.

Facilities performing stem cell transplants must be accredited by the Foundation for the Accreditation of Cellular Therapy and the Joint Accreditation Committee and compliant with the FACT_JACIE International Standards for Cellular Therapy Product Collection, Processing, and Administration manual.

### Definitions of Stages in Hodgkin’s Disease

<table>
<thead>
<tr>
<th>Stage I: Involvement of a single lymph node region (I) or localized involvement of a single extralymphatic organ or site (IE)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Stage II: Involvement of two or more lymph node regions on the same side of the diaphragm (II) or localized involvement of a single associated extralymphatic organ or site and its regional lymph node(s), with or without involvement of other lymph node regions on the same side of the diaphragm (IIE).</th>
</tr>
</thead>
</table>

**Note:** The number of lymph node regions involved may be indicated by a subscript (e.g., II3)

<table>
<thead>
<tr>
<th>Stage III: Involvement of lymph node regions on both sides of the diaphragm (III), which may also be accompanied by localized involvement of an associated extralymphatic organ or site (IIIE), by involvement of the spleen (IIIS) or by both (IIIE+S)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Stage IV: Disseminated (multifocal) involvement of one or more extralymphatic organs, with or without associated lymph node involvement, or isolated extralymphatic organ with distant (nonregional) nodal involvement.</th>
</tr>
</thead>
</table>

A. No Systemic Symptoms Present
B. Unexplained fevers >38 degrees C; drenching night sweats; or weight loss 10% of body weight (within 6 months prior to diagnosis)

### Special Instructions: N/A

### Line of Business Applicability:

For Medicaid/Medicaid Expansion Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the codes being submitted and considered for review being included on either the Michigan Medicaid Fee Schedule (located at: [http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--.00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--.00.html)), the Illinois Medicaid Fee Schedule (located at: [http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx](http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx)), or the Iowa Medicaid Fee Schedule (located at: [http://dhs.iowa.gov/ime/providers/csrp/fee-schedule](http://dhs.iowa.gov/ime/providers/csrp/fee-schedule)). If there is a discrepancy between this policy and either the Michigan Medicaid Provider Manual (located at: [http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--.00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--.00.html)), the Illinois Medicaid Provider Manual (located at: [http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx](http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx)), or the Iowa Medicaid Provider Manual (located at: [http://dhs.iowa.gov/policy-manuals/medicaid-provider](http://dhs.iowa.gov/policy-manuals/medicaid-provider)) the applicable Medicaid Provider Manual will govern.
For **Medicare** members, coverage is determined by the Centers for Medicare and Medicaid Services (CMS). If a coverage determination has not been adopted by CMS, this policy applies. Medicare Fee Schedules can be found on the CMS website (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html).


<table>
<thead>
<tr>
<th>Approved by: _______________________________</th>
<th>Date: 04/21/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Chief Operating Officer</td>
<td></td>
</tr>
</tbody>
</table>

**Reviewed and approved by:**

<table>
<thead>
<tr>
<th>Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy and Procedure Committee:</td>
</tr>
<tr>
<td>Medical Policy Operations Committee:</td>
</tr>
<tr>
<td>Physician Advisory Committee:</td>
</tr>
<tr>
<td>Healthcare Compliance Subcommittee:</td>
</tr>
</tbody>
</table>

**References:**

5. NMDP/ASBMT Recommended Timing for Transplant Consultation, 2013.

<table>
<thead>
<tr>
<th>State Letters/Bulletins</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS National/Local Coverage Determination (NCD/LCD)</td>
<td></td>
</tr>
<tr>
<td>Medicare Managed Care Manual:</td>
<td></td>
</tr>
<tr>
<td>Medicaid CFR:</td>
<td></td>
</tr>
<tr>
<td>State Administrative Codes:</td>
<td></td>
</tr>
<tr>
<td>Contract Requirements:</td>
<td></td>
</tr>
<tr>
<td>Related Policies:</td>
<td></td>
</tr>
</tbody>
</table>