Public Statement:

Autologous stem cell transplant is covered for patients with multiple myeloma who meet criteria, with authorization through case management by American Health Holding at 877-815-1017 (option 2).

Medical Policy Statement:

High dose chemotherapy with autologous bone marrow, stem cell, or progenitor cell support for the treatment of myeloma is covered for the treatment of:

- newly diagnosed or responsive multiple myeloma;
- responsive myeloma that has relapsed after a durable complete or partial remission following an initial autologous transplant.

Tandem high-dose chemotherapy with autologous stem-cell support to treat newly diagnosed or responsive multiple myeloma is covered when medically indicated. Only two (2) courses of therapy given in tandem are covered.

Tandem high-dose chemotherapy is considered to be a second course of myeloablative chemotherapy followed by autologous stem-cell support given within 3 to 6 months of the initial course.

Limits:

ARBenefits reserves the right to alter, amend, change or supplement medical policies as needed. ARBenefits reviews and authorizes services and substances. CPT and HCPCS codes are listed as a convenience and any absent, new or changed codes do not alter the intent of the policy.
High dose chemotherapy with allogeneic stem and/or progenitor cell support is not covered following autologous stem and/or progenitor cell transplantation.

Tandem high dose chemotherapy with autologous stem and/or progenitor cell support is not covered for any diseases other than multiple myeloma and Waldenstrom's macroglobulinemia.

A second or subsequent course of high dose chemotherapy with allogeneic or autologous stem cell and/or progenitor cell support for treatment of relapsed disease is covered only for patients who have shown a complete response to the initial high dose chemotherapy/transplant regimen.

Coverage of high dose chemotherapy with allogeneic or autologous stem and/or progenitor cell support for a patient with two active malignant diseases is covered only if both diseases have a specific coverage policy and the patient meets all criteria for both high dose chemotherapy with stem and/or progenitor cell treatment regimens.

Background:

Rotta et al (2009) reported long term results of 102 patients treated with auto/allo HCT. Forty-two percent of the patients developed grade 2 to 4 GVHD and 74% developed chronic GVHD. Among 95 patients with detectable disease, 59 achieved complete remissions. Five-year nonrelapse mortality was 18% with 95% of that attributable to GVHD or infection.

Bensinger, in another review article in 2009, continues to state that the disease remains incurable for all but a small fraction of patients despite good response rates with new drugs and the mortality associated with allogeneic transplants.

Vesole (2009) reported results of 32 patients enrolled in a Phase II trial of autologous stem cell transplant followed by a mini-allogeneic stem cell transplant. Twenty-three patients completed both transplants. There were 7 complete and 11 partial remissions, 2 with no response and 3 were not evaluable. Acute grade III-IV GVHD was seen in 4 patients, chronic GVHD in 13 patients. “Because a plateau in PFS or OS was not observed with this treatment approach even in patients achieving CR, we suggest that future studies use posttransplantation maintenance therapy.”

In a review and meta-analysis of tandem versus single autologous hematopoietic cell transplantation to treat multiple myeloma, Kumar (2009) looked at six RCTs enrolling 1803 patients meeting inclusion criteria. Patients with tandem AHCT did not have better OS or EFS. They did have statistically significant response rates but this was associated with a statistically significant increase in treatment-related mortality.
In December 2010, at the American Society of Hematology annual meeting in Orlando, Drs. Amrita Krishnan and Edward Stadtmauer presented 3-year preliminary results of a phase III trial that enrolled 710 patients with standard risk myeloma in 43 centers in the United States. All patients received high-dose melphalan and an autologous stem cell transplant. The 484 patients without a sibling match were to receive a second autologous transplant with Melphalan ("allo-allo"). The 226 who had a sibling match were to receive a nonmyeloablative conditioning regimen followed by an allogeneic stem cell transplant and 2 Gy of total body irradiation ("allo-auto"). In each group 82% went on to a second transplant. For those patients who received a second transplant progression free survival rates, overall survival rates and progression/relapse rates were similar in both groups. Treatment related mortality was significantly different in the two groups; 4% for the allo-allo group and 12% for the allo-auto group. Dr. Stadtmauer commented: "This is a preliminary result but it certainly is not supportive of routine use of nonmyeloablative allogeneic transplant in standard-risk patients. …With longer-term follow-up, if these results hold out, then I think our enthusiasm will disappear."

References:


Cavo M, Tosi P, et al. (2007) Prospective, randomized study of single compared with


Fermand JP, Ravaud P.(1997) High dose therapy (HDT) and autologous peripheral blood stem cell (PBSC) transplantation performed either as first-line therapy or as a rescue treatment: similar effect on overall survival in myeloma patients. VI International Workshop on Multiple Myeloma 1997; Boston; Harvard Med School and Dana-Farber Cancer Institute.

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Application to Products

This policy applies to ARBenefits. Consult ARBenefits Summary Plan Description (SPD) for additional information.

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