Allogeneic Hematopoietic Stem-Cell Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms

Policy Number: 8.01.21
Origination: 12/2001

Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) will provide coverage for allogeneic hematopoietic stem-cell transplantation for myelodysplastic and myeloproliferative neoplasms when it is determined to be medically necessary because the criteria shown below are met.

When Policy Topic is covered
Myeloablative allogeneic HSCT may be considered medically necessary as a treatment of
- myelodysplastic syndromes (see Considerations) or
- myeloproliferative neoplasms (see Considerations).

Reduced-intensity conditioning allogeneic HSCT may be considered medically necessary as a treatment of
- myelodysplastic syndromes (see Considerations) or
- myeloproliferative neoplasms (see Considerations)
in patients who for medical reasons would be unable to tolerate a myeloablative conditioning regimen. (see Considerations).

When Policy Topic is not covered
Myeloablative allogeneic HSCT or reduced-intensity conditioning allogeneic HSCT for myelodysplastic syndromes and myeloproliferative neoplasms that does not meet the criteria in the Considerations section is considered investigational.

Considerations
The myeloid neoplasms are categorized according to criteria developed by the World Health Organization. They are risk-stratified according to the International Prognostic Scoring System (IPSS).
**2008 WHO Classification Scheme for Myeloid Neoplasms**

1. **Acute myeloid leukemia**
2. **Myelodysplastic syndromes (MDS)**
3. **Myeloproliferative neoplasms (MPN)**
   - 3.1. Chronic myelogenous leukemia
   - 3.2. Polycythemia vera
   - 3.3. Essential thrombocythemia
   - 3.4. Primary myelofibrosis
   - 3.5. Chronic neutrophilic leukemia
   - 3.6. Chronic eosinophilic leukemia, not otherwise categorized
   - 3.7. Hypereosinophilic leukemia
   - 3.8. Mast cell disease
   - 3.9. MPNs, unclassifiable
4. **MDS/MPN**
   - 4.1. Chronic myelomonocytic leukemia
   - 4.2. Juvenile myelomonocytic leukemia
   - 4.3. Atypical chronic myeloid leukemia
   - 4.4. MDS/MPN, unclassifiable
5. **Myeloid neoplasms associated with eosinophilia and abnormalities of PDGFRA, PDGFRB, or FGFR1**
   - 5.1. Myeloid neoplasms associate with PDGFRA rearrangement
   - 5.2. Myeloid neoplasms associate with PDGFRB rearrangement
   - 5.3. Myeloid neoplasms associate with FGFR1 rearrangement (8p11 myeloproliferative syndrome)

**2008 WHO Classification of MDS**

1. Refractory anemia (RA)
2. RA with ring sideroblasts (RARS)
3. Refractory cytopenia with multilineage dysplasia (RCMD)
4. RCMD with ring sideroblasts
5. RA with excess blasts 1 and 2 (RAEB 1 and 2)
6. del 5q syndrome
7. unclassified MDS

**Risk Stratification of MDS**

Risk stratification for MDS is performed using the IPSS. This system was developed after pooling data from 7 previous studies that used independent, risk-based prognostic factors. The prognostic model and the scoring system were built based on blast count, degree of cytopenia, and blast percentage. Risk scores were weighted relative to their statistical power. This system is widely used to divide patients into two categories: (1) low risk and (2) high-risk groups. The low-risk group includes low risk and Int-1 IPSS groups; the goals in low-risk MDS patients are to improve quality of life and achieve transfusion independence. In the high-risk group — which includes Int-2 and high-risk IPSS groups — the goals are slowing the progression of disease to AML and improving survival. The IPSS is usually calculated on diagnosis. The role of lactate dehydrogenase, marrow fibrosis, and beta 2-microglobulin also should be considered after establishing the
IPSS. If elevated, the prognostic category becomes worse by one category change.

| Table 1. International Prognostic Scoring System: Myelodysplastic Syndrome Prognostic Variables |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|
| Variable                        | 0               | 0.5             | 1.0             | 1.5             | 2.0             |
| Marrow blasts (5)               | < 5             | 5-10            | 11-20           | 21-30           |
| Karyotype                       | Good            | Intermediate    | Poor            |
| Cytopenias                      | 0/1             | 2/3             |

| Table 2. International Prognostic Scoring System: Myelodysplastic Syndrome Clinical Outcomes |
|---------------------------------|-----------------|-----------------|-----------------|
| Risk Group                      | Total score     | Median survival, yrs | Time for 25% to progress to AML, years |
| Low                             | 0               | 5.7             | 9.4             |
| Intermediate-1                  | 0.5-1.0         | 3.5             | 3.3             |
| Intermediate-2                  | 1.5-2.0         | 1.2             | 1.12            |
| High                            | 2.5 or more     | 0.4             | 0.2             |

AML: acute myelocytic leukemia.

An updated 5-category IPSS has been proposed for prognosis in patients with primary MDS or secondary AML to account for chromosomal abnormalities frequently seen in MDS.(1) This system stratifies patients into 5 categories: very poor, poor, intermediate, good, and very good. There has been investigation into using the 5-category IPSS to better characterize risk in MDS.

Given the long natural history of MDS, allogeneic HSCT is typically considered in those with increasing numbers of blasts, signaling a possible transformation to acute myeloid leukemia. Subtypes falling into this category include refractory anemia with excess blasts, refractory anemia with excess blasts in transformation, or chronic myelomonocytic leukemia.

Patients with refractory anemia with or without ringed sideroblasts may be considered candidates for allogeneic HSCT when chromosomal abnormalities are present or the disorder is associated with the development of significant cytopenias (e.g., neutrophils less 500/mm3, platelets less than 20,000/mm3).

Patients with MPNs may be considered candidates for allogeneic HSCT when there is progression to myelofibrosis, or when there is evolution toward acute leukemia. In addition, allogeneic HSCT may be considered in patients with essential thrombocythemia with an associated thrombotic or hemorrhagic disorder. There are no suitable U.S. Food and Drug Administration (FDA) -approved therapies for
these patients, only supportive care. The use of allogeneic HSCT should be based on cytopenias, transfusion dependence, increasing blast percentage over 5%, and age.

Some patients for whom a conventional myeloablative allotransplant could be curative may be considered candidates for RIC allogeneic HSCT. These include those patients whose age (typically older than 60 years) or comorbidities (e.g., liver or kidney dysfunction, generalized debilitation, prior intensive chemotherapy, low Karnofsky Performance Status) preclude use of a standard myeloablative conditioning regimen. The ideal allogeneic donors are HLA-identical siblings, matched at the HLA-A, B, and DR loci (6 of 6). Related donors mismatched at one locus are also considered suitable donors. A matched, unrelated donor (MUD) identified through the National Marrow Donor Registry is typically the next option considered. Recently, there has been interest in haploidentical donors, typically a parent or a child of the patient, where usually there is sharing of only 3 of the 6 major histocompatibility antigens. The majority of patients will have such a donor; however, the risk of GVHD and overall morbidity of the procedure may be severe, and experience with these donors is not as extensive as that with matched donors.

Clinical input suggests RIC allogeneic HSCT may be considered for patients as follows:

**MDS**
- IPSS intermediate-2 or high risk
- RBC transfusion dependence
- Neutropenia
- Thrombocytopenia
- High risk cytogenetics
- Increasing blast percentage

**MPN**
- Cytopenias
- Transfusion dependence
- Increasing blast percentage over 5%
- Age 60-65 years

### Description of Procedure or Service

<table>
<thead>
<tr>
<th>Populations</th>
<th>Interventions</th>
<th>Comparators</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals:</td>
<td>Interventions of interest are:</td>
<td>Comparators of interest are:</td>
<td>Relevant outcomes include:</td>
</tr>
<tr>
<td>With myelodysplastic syndrome</td>
<td>▪ Myeloablative conditioning allogeneic hematopoietic stem cell transplant</td>
<td>▪ Standard care</td>
<td>▪ Overall survival</td>
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<tr>
<td>With myeloproliferative neoplasms</td>
<td></td>
<td></td>
<td>▪ Disease-specific survival</td>
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<td>▪ Treatment-related mortality</td>
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<td>▪ Treatment-related morbidity</td>
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| Individuals:                  | Interventions of interest are:                   | Comparators of interest are:  | Relevant outcomes include:                                    |
| With                         |                                                   |                               | ▪ Overall survival                                            |
|                              |                                                   |                               | ▪ Disease-specific survival                                  |
|                              |                                                   |                               | ▪ Treatment-related mortality                                |
|                              |                                                   |                               | ▪ Treatment-related morbidity                                |
Myelodysplastic syndromes and myeloproliferative neoplasms refer to a heterogeneous group of clonal hematopoietic disorders with the potential to transform into acute myelocytic leukemia (AML). Allogeneic hematopoietic stem-cell transplantation (HSCT) has been proposed as a curative treatment option for patients with these disorders.

The evidence for use of myeloablative conditioning allo-HSCT in individuals who have MDS and MPN includes case series of patients, which are often heterogeneous in terms of diseases included. Relevant outcomes are overall survival, disease-specific survival, and treatment-related morbidity and mortality. Primarily uncontrolled, observational studies of HSCT for MDS report a relatively large range of overall and progression-free survival values, which reflects the heterogeneity in patient populations, conditioning regimens, and other factors. Reported estimates for 3- to 5-year overall survival of approximately 40% to 50% are typical. For HSCT for MPN, data are more limited. At least 1 comparative study of HSCT for myelofibrosis demonstrated improved survival with HSCT compared with standard therapy.

The evidence for use of reduced-intensity conditioning (RIC) allo-HSCT in individuals who have MDS and MPN includes primarily retrospective observational series. Relevant outcomes are overall survival, disease-specific survival, and treatment-related morbidity and mortality. Direct, prospective comparisons of outcomes after HSCT with either myeloablative conditioning or RIC in either MDS or MPN are not available. Evidence from retrospective nonrandomized comparisons suggests that RIC may be used in patients who are older and with more comorbidities without significantly worsening overall survival. RIC appears to be associated with lower rates of nonrelapse mortality but higher cancer relapse than myeloablative HSCT.

HSCT is at present the only potentially curative treatment option for patients with myelodysplastic syndromes (MDSs) and myeloproliferative neoplasms (MPNs). The absence of other curative therapies coupled with clinical data and input permit the conclusion that allogeneic HSCT using either a myeloablative or reduced-intensity conditioning (RIC) regimen is medically necessary in appropriately selected patients with these conditions. Patient selection is guided by age and disease risk factors, as outlined in the Considerations section.

**Hematopoietic Stem-Cell Transplantation**

Hematopoietic stem cells may be obtained from the transplant recipient (autologous HSCT) or from a donor (allogeneic HSCT). 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 “naïve” 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.

Immunologic compatibility between infused hematopoietic stem cells and the recipient is not an issue in autologous HSCT. However, immunologic compatibility between donor and patient is a critical factor for achieving a good outcome of allogeneic HSCT. Compatibility is established by typing of human leukocyte antigens (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.

**Conventional Preparative Conditioning for HSCT**

The conventional (“classical”) practice of allogeneic HSCT involves administration of cytotoxic agents (e.g., 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 HSCT, immune suppressant drugs are required to minimize graft rejection and GVHD, which also increases susceptibility of the patient to opportunistic infections.

**Reduced-Intensity Conditioning for Allogeneic HSCT**

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, but also to minimize as much as possible associated treatment-related morbidity and non-relapse 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 HSCT 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.

**Myelodysplastic Syndromes**

**Overview**
Myelodysplastic syndromes (MDS) can occur as a primary (idiopathic) disease, or be secondary to cytotoxic therapy, ionizing radiation, or other environmental insult. Chromosomal abnormalities are seen in 40%–60% of patients, frequently involving deletions of chromosome 5 or 7, or an extra chromosome as in trisomy 8. Signs and symptoms of anemia, often complicated by infections or bleeding, are common in MDS; some patients exhibit systemic symptoms or features of autoimmunity that may be indicative of their disease pathogenesis. The vast majority of MDS diagnoses occur in individuals over the age of 55–60 years, with an age-adjusted incidence of about 62% among individuals over age 70 years. Patients either succumb to disease progression to AML or to complications of pancytopenias. Patients with higher blast counts or complex cytogenetic abnormalities have a greater likelihood of progressing to AML than do other patients.

**MDS Classification and Prognosis**
For the past 20 years, the French-American-British (FAB) system has been used to classify MDS into 5 subtypes as follows: 1) refractory anemia (RA); 2) refractory anemia with ringed sideroblasts (RARS); 3) refractory anemia with excess blasts (RAEB); 4) refractory anemia with excess blasts in transformation (RAEBT); and, 5) chronic myelomonocytic leukemia (CMML). However, the FAB system has been supplanted by that of the World Health Organization (WHO), which records the number of lineages in which dysplasia is seen (unilineage versus multilineage), separates the 5q- syndrome, and reduces the threshold maximum blast percentage for the diagnosis of MDS from 30% to 20% (see Considerations for WHO classification scheme for myeloid neoplasms).

The most commonly used prognostic scoring system for MDS is the International Prognostic Scoring System (IPSS), which groups patients into 1 of 4 prognostic categories based on the number of cytopenias, cytogenetic profile, and the percentage of blasts in the bone marrow (see Policy Guidelines section). This system underweights the clinical importance of severe, life-threatening neutropenia and thrombocytopenia in therapeutic decisions and does not account for the rate of change in critical parameters, such as peripheral blood counts or blast percentage. However, the IPSS has been useful in comparative analysis of clinical trial results and its utility confirmed at many institutions. A second prognostic scoring system incorporates the WHO subgroup classification that accounts for blast percentage, cytogenetics, and severity of cytopenias as assessed by transfusion requirements. The WPSS uses a 6-category system which allows more precise prognostication of overall survival duration as well as risk for progression to AML. This system, however, is not yet in widespread use in clinical trials.
MDS Treatment
Treatment of smoldering or nonprogressing MDS has in the past involved best supportive care including red blood cell (RBC) and platelet transfusions and antibiotics. Active therapy was given only when MDS progressed to AML or resembled AML with severe cytopenias. A diverse array of therapies are now available to treat MDS, including hematopoietic growth factors (eg, erythropoietin, darbepoetin, granulocyte colony-stimulating factor), transcriptional-modifying therapy (eg, U.S. Food and Drug Administration [FDA]‒approved hypomethylating agents, nonapproved histone deacetylase inhibitors), immunomodulators (eg, lenalidomide, thalidomide, antithymocyte globulin, cyclosporine A), low-dose chemotherapy (eg, cytarabine), and allogeneic HSCT. Given the spectrum of treatments available, the goal of therapy must be decided upfront, whether it is to improve anemia; thrombocytopenia; or neutropenia, eliminate the need for red blood cell transfusion, achieve complete remission, or cure the disease.

Allogeneic HSCT is the only approach with curative potential, but its use is governed by patient age, performance status, medical comorbidities, the patient’s risk preference, and severity of MDS at presentation.

Chronic Myeloproliferative Neoplasms

Overview of Chronic Myeloproliferative Neoplasms
Chronic MPNs are clonal bone marrow stem-cell disorders; as a group, an approximate total of 8400 MPNs are diagnosed annually in the United States. Like MDS, MPNs primarily occur in older individuals, with approximately 67% reported in patients aged 60 years and older.

The MPNs are characterized by the slow but relentless expansion of a clone of cells with the potential evolution into a blast crisis similar to AML. They share a common stem cell-derived clonal heritage, with phenotypic diversity attributed to abnormal variations in signal transduction as the result of a spectrum of mutations that affect protein tyrosine kinases or related molecules. The unifying characteristic common to all MPNs is effective clonal myeloproliferation resulting in peripheral granulocytosis, thrombocytosis, or erythrocytosis that is devoid of dyserythropoiesis, granulocytic dysplasia, or monocytosis.

MPN Classification
In 2008, a new WHO classification scheme replaced the term chronic myeloproliferative disorder with the term myeloproliferative neoplasms (MPN). These are a subdivision of myeloid neoplasms that includes the 4 classic disorders: chronic myeloid leukemia (CML), polycythemia vera, essential thrombocytopenia, and primary myelofibrosis; the WHO classification also includes chronic neutrophilic leukemia, chronic eosinophilic leukemia/hypereosinophilic syndrome, mast cell disease, and MPNs unclassifiable (see Considerations).

MPN Treatment
In indolent, nonprogressing cases, therapeutic approaches are based on relief of symptoms. Supportive therapy may include prevention of thromboembolic events.
Hydroxyurea may be used in cases of high-risk essential thrombocytosis and polycythemia vera and intermediate- and high-risk primary myelofibrosis.

In November 2011, FDA approved the orally-administered selective Janus kinase 1 and 2 inhibitor ruxolitinib for the treatment of intermediate- or high-risk myelofibrosis. Ruxolitinib has been associated with improved OS, spleen size, and symptoms of myelofibrosis when compared with placebo.(1) The COMFORT-II trial compared ruxolitinib to best available therapy in patients with intermediate- and high-risk myelofibrosis, and demonstrated improvements in spleen volume and OS.(2) In a randomized trial comparing ruxolitinib with best available therapy, including antineoplastic agents, most commonly hydroxyurea, glucocorticoids, and no therapy, for myelofibrosis, Harrison et al demonstrated improvements in spleen size and quality of life, but not OS.(3)

MA allogeneic HSCT has been considered the only potentially curative therapy, but because most patients are of advanced age with attendant comorbidities, its use is limited to those who can tolerate the often severe treatment-related adverse effects of this procedure. However, the use of RIC of conditioning regimens for allogeneic HSCT has extended the potential benefits of this procedure to selected individuals with these disorders.

Rationale
This evidence review was originally created in December 1999 and has been updated periodically with literature reviews, most recently through October 27, 2015. Following is a summary of the key literature to date.

Myelodysplastic Syndromes

Conventional Preparative Conditioning Hematopoietic Stem Cell Transplantation for Myelodysplastic Syndromes
Despite the successes seen with new drugs now available to treat myelodysplastic syndromes (MDS; eg, decitabine, azacitidine, lenalidomide), allogeneic hematopoietic stem cell transplantation (allo-HSCT) is the only treatment capable of complete and permanent eradication of the MDS clone.(5)

A 2009 review of HSCT for MDS evaluated the evidence for allo-HSCT with myeloablative (MA) conditioning for MDS.(6) The authors included 24 studies (prospective and retrospective) published between 2000 and 2008 that included a total 1378 cases (age range, 32-59 years). Most patients (n=885) received matched-related donor allo-HSCT, with other donor types including syngeneic, matched, unrelated donor, mismatched unrelated donor, and umbilical cord blood. Most studies included de novo and secondary MDS, chronic myelomonocytic leukemia (CML), myeloproliferative neoplasms (MPN), de novo and secondary acute myelocytic leukemia (AML), and transformed AML. Peripheral blood and bone marrow stem cell grafts were allowed in most studies. The most commonly used conditioning regimens were busulfan plus cyclophosphamide (CY) and CY plus total body irradiation, with cyclosporine A (CYA) used for graft-versus-host
disease (GVHD) prophylaxis. Length of follow-up ranged from 5 months to approximately 8 years. Grades II to IV acute GVHD varied from 18% to 100%. Relapse risk ranged from 24% at 1 year to 36% at 5 years. Overall survival (OS) ranged from 25% at 2 years to 52% at 4 years, with nonrelapse mortality (NRM) ranging from 19% at day 100 to 61% at 5 years.

A review from the American Society for Blood and Marrow Transplantation (ASBMT) in 2009 assembled and evaluated the evidence related to HSCT in the therapy of MDS, with associated treatment recommendations.(7) The authors concluded that outcomes improved with early HSCT for patients with an International Prognostic Scoring System (IPSS) score of intermediate-2 or high-risk at diagnosis who had a suitable donor and met the transplant center’s eligibility criteria, and for selected patients with a low or intermediate-1 risk IPSS score at diagnosis who had a poor prognostic feature not included in the IPSS (ie, older age, refractory cytopenias). Koenecke et al (2015) evaluated the impact on the revised 5-category IPSS score (IPSS-5) on outcomes after HSCT in patients with MDS or secondary acute myeloid leukemia (evolved from MDS).(8) In a cohort of 903 patients retrospectively identified from the European Society for Blood and Marrow Transplantation database, those with poor and very poor risk had shorter relapse-free survival (RFS) and OS than those with very good, good, or intermediate risk. However, the ways that transplant management strategies should change based on cytogenetic abnormalities are not currently well-defined.

Reduced-Intensity Conditioning HSCT for MDS
Evidence from a number of largely heterogeneous, uncontrolled studies of reduced-intensity conditioning (RIC) with allo-HSCT have shown long-term remissions (ie, >4 years) can be achieved, often with reduced treatment-related morbidity and mortality, in patients with MDS/AML who otherwise would not be candidates for MA conditioning regimens.(6,9-19) These prospective and retrospective studies included cohorts of 16 to 215 patients similar to those in the MA allo-HSCT studies. The most common conditioning regimens used were fludarabine-based, with CYA and tacrolimus used for GVHD prophylaxis. The reported incidence of grades II to IV GVHD was 9% to 63%, with relapse risk of 6% to 61%. OS rates ranged between 44% at 1 year and 46% at 5 years (median follow-up range, 14 months to >4 years).

Zeng et al (2014) conducted a systematic review and meta-analysis comparing outcomes for patients with MDS or AML treated with HSCT with either RIC or MA conditioning.(20) The review included 8 studies (2 prospective, 8 retrospective), with a total of 6464 AML/MDS patients. A total of 171 received RIC and 4893 received MA conditioning. Overall, RIC-treated patients were older and more likely to have multiple comorbidities. In pooled analysis, OS, RFS, and NRM did not differ significantly between patients receiving RIC and MA conditioning. Relapse incidence was significantly lower in the MA conditioning arm (odds ratio for RIC vs MA conditioning, 1.41; 95% confidence interval [CI], 1.24 to 1.59; p<0.001).

Aoki et al compared RIC with MA conditioning in a retrospective cohort of 448 patients aged 50 to 69 years with advanced MDS (refractory anemia with excess
blasts or refractory anemia in transformation).(21) Of the total, 197 (44%) and 251 (56%) received MA conditioning or RIC, respectively. The groups differed at baseline: patients who received RIC were significantly more likely to be 60 to 69 years old (vs 50-59 years; 47% for RIC vs 47% for MA; p=0.001), and less likely to receive an unrelated donor transplant (54% vs 70%; p=0.001). Three-year OS did not differ between groups (44.1% for RIC vs 42.7% for MA; p=0.330).

Although patients treated with RIC had a significantly lower 3-year cumulative incidence of NRM (25.6% vs 37.9%; p=0.002), but they had significantly higher 3-year incidence of relapse than patients treated with MA conditioning (29.9% vs 22.8%; p=0.029).

In 2012, Kim et al published a phase 3 randomized trial (N=83 patients) comparing the toxicities of 2 different conditioning regimens (reduced CY, fludarabine, and antithymocyte globulin [ATG]; standard CYATG). (22) Four patients had MDS, and the remaining patients had severe aplastic anemia. Overall, the incidence of reported toxicities were lower in patients receiving the reduced-conditioning regimen (23% vs 55%; p=0.003). Subgroup analyses showed no differences in the overall results based on differential diagnosis.(22)

In general, these RIC trials showed a low rate of engraftment failure and low NRM, but at the cost of a higher relapse rate than with MA allo-HSCT. However, in the absence of prospective, comparative, randomized trials, only indirect comparisons can be made between the relative clinical benefits and harms associated with MA and RIC regimens with allo-HSCT. Furthermore, no randomized trials have been published in which RIC with allo-HSCT has been compared with conventional chemotherapy alone, which has been the standard of care in patients with MDS/AML for whom MA chemotherapy and allo-HSCT are contraindicated. Nonetheless, given the absence of curative therapies for these patients, coupled with clinical input (see next), RIC allo-HSCT may be considered medically necessary for patients with MDS who could benefit from allo-HSCT but who for medical reasons would be unable to tolerate a MA conditioning regimen.

The 2009 ASBMT systematic review (previously described) addressed the evidence supporting RIC compared with MA conditioning regimens and made the following conclusions: “There are insufficient data to make a recommendation for an optimal conditioning regimen intensity. A range of dose intensities is currently being investigated, and the optimal approach will likely depend on disease and patient characteristics, such as age and comorbidities.”(7)

Other recent reviews concur with the ASBMT recommendations.(23-28)

**Outcomes After MDS in Mixed MDS Populations**

A number of studies, primarily retrospective, continue to report outcomes from HSCT for MDS in variety of patient populations and to evaluate the impact of specific patient, conditioning, and donor characteristics on outcomes; representative studies are summarized in Table 1.

**Table 1: Case Series of HSCT Treatment for MDS**
<table>
<thead>
<tr>
<th>Study</th>
<th>Patient Population</th>
<th>Type of HSCT</th>
<th>Summary of Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basquiera et al (2015)</td>
<td>52 pediatric patients with MDS</td>
<td>▪ Allo-HSCT</td>
<td>▪ 5-y DFS: 50%</td>
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<td></td>
<td></td>
<td>▪ 59% with related donors</td>
<td>▪ 5-y OS: 55%</td>
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<tr>
<td></td>
<td></td>
<td>▪ Stem cell source:</td>
<td>▪ Bone marrow, 63%</td>
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<td>▪</td>
<td>▪ Peripheral blood, 26%</td>
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<td></td>
<td></td>
<td>▪</td>
<td>▪ Umbilical cord blood, 11%</td>
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<tr>
<td>Boehm et al (2014)</td>
<td>60 adults with MDS or secondary AML</td>
<td>▪ Allo-HSCT</td>
<td>10-y OS: 46%</td>
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<td></td>
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<td>▪ MA conditioning in 36 patients; RIC conditioning in 24 patients</td>
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<td>Damaj et al (2014)</td>
<td>128 adults with MDS, 40 of whom received AZA before HSCT and 88 who received BSC</td>
<td>RIC allo-HSCT</td>
<td>▪ 3-y OS: 53% in AZA group vs 53% in BSC group (p=0.69)</td>
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<td>▪ 3-y RFS: 37% in AZA group vs 42% in BSC group (p=0.78)</td>
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<td>▪ 3-y NRM: 20% in AZA group vs 23% in BSC group (p=0.74)</td>
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<tr>
<td>Di Stasi et al (2014)</td>
<td>227 patients with MDS or AML</td>
<td>▪ Allo-HSCT</td>
<td>3-y PFS for patients in remission:</td>
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<tr>
<td></td>
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<td>▪ Donor source:</td>
<td>▪ 57% for matched-related</td>
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<td>▪ 45% for matched-unrelated</td>
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<td>▪</td>
<td>▪ 41% for haploidentical</td>
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<td>▪</td>
<td>▪ (p=0.417)</td>
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<tr>
<td>Onida et al (2014)</td>
<td>▪ 523 patients with MDS treated with HSCT</td>
<td>▪ Allo-HSCT</td>
<td>5-y OS based on IPSS cytogenic risk group:</td>
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<tr>
<td></td>
<td>▪ IPSS cytogenic risk group:</td>
<td>▪ RIC conditioning in 12%</td>
<td>▪ Good risk: 48%</td>
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<td></td>
<td>▪ Good risk: 53.5%</td>
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<td>▪ Intermediate risk: 45%</td>
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<tr>
<td></td>
<td>▪ Intermediate risk: 24.5%</td>
<td></td>
<td>▪ Poor risk: 30%</td>
</tr>
<tr>
<td></td>
<td>▪ Poor risk: 22%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oran et al (2014)</td>
<td>▪ 256 patients with MDS</td>
<td>▪ Allo-HSCT</td>
<td>3-y EFS based on cytoreductive therapy:</td>
</tr>
<tr>
<td></td>
<td>▪ Pretreatment:</td>
<td>▪ RIC conditioning in 36.7%</td>
<td>▪ No cytoreductive chemo: 44.2%</td>
</tr>
<tr>
<td></td>
<td>▪ No cytoreductive chemo: 30.5%</td>
<td></td>
<td>▪ Chemo: 30.6%</td>
</tr>
<tr>
<td></td>
<td>▪ Chemo: 15.6%</td>
<td></td>
<td>▪ HMA: 34.2%</td>
</tr>
<tr>
<td></td>
<td>▪ HMA: 47.7%</td>
<td></td>
<td>▪ Chemo + HMA: 32.8% (p=0.50)</td>
</tr>
<tr>
<td></td>
<td>▪ Chemo + HMA: 6.2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Basquiera et al (2015)\(^{36}\)
- 84 adults with MDS treated with HSCT
  - Cytogenic risk group:
    - Standard risk: 65.5%
    - Adverse risk: 12.6%
    - Unknown: 21.9%
  - Allo-HSCT
  - RIC conditioning in 31.1%

<table>
<thead>
<tr>
<th>OS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median: 23.5 mo (95% CI, 1.7 to 45.3 mo)</td>
</tr>
<tr>
<td>1-y: 61% (95% CI, 50% to 70%)</td>
</tr>
<tr>
<td>4-y: 38% (95% CI, 27% to 49%)</td>
</tr>
</tbody>
</table>

### Symeonidis et al (2015)\(^{37}\)
- 513 adults with CMML treated with HSCT
  - Pretreatment:
    - No prior disease modifying therapy: 28%
    - Disease-modifying therapy: 72%
  - Allo-HSCT
  - RIC conditioning in 41.6%

<table>
<thead>
<tr>
<th>NRM:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-y: 31%</td>
</tr>
<tr>
<td>4-y: 41%</td>
</tr>
<tr>
<td>4-y RFS: 27%</td>
</tr>
<tr>
<td>4-y OS: 33%</td>
</tr>
</tbody>
</table>

### Section Summary: Myelodysplastic Syndromes
Primarily uncontrolled, observational studies of HSCT for MDS have reported a relatively large range of OS and progression-free survival (PFS) values, which reflects the heterogeneity in patient populations, conditioning regimens, and other factors. Reported estimates for 3- to 5-year OS of approximately 40% to 50% are typical. Direct comparisons between RIC and MA conditioning prior to HSCT with randomly selected populations are not available. Evidence from nonrandomized comparisons has suggested that RIC may be used in patients who are older and with more comorbidities without significantly worsening OS. RIC appears to be associated with lower rates of NRM but higher cancer relapse than MA HSCT.

### Myeloproliferative Neoplasms
Data on therapy for MPN are sparse.(16,38,39) As outlined previously in this evidence review, with the exception of MA chemotherapy and allo-HSCT, no therapy has yet been proven to be curative or to prolong survival of patients with MPN.

The largest study identified of allo-HSCT for primary myelofibrosis comes from analysis of the outcomes of 289 patients treated between 1989 and 2002, from the database of the Center for International Bone Marrow Transplant Research.
Median age was 47 years (range, 18-73 years). Donors were human leukocyte antigen (HLA)-identical siblings in 162 patients, unrelated individuals in 101 patients, and HLA nonidentical family members in 26 patients. Patients were treated with a variety of conditioning regimens and GVHD prophylaxis regimens. Splenectomy was performed in 65 patients before transplantation. The 100-day treatment-related mortality was 18% for HLA-identical sibling transplants, 35% for unrelated transplants, and 19% for transplants from alternative-related donors. Corresponding 5-year OS rates were 37%, 30%, and 40%, respectively. Disease-free survival (DFS rates were 33%, 27%, and 22%, respectively. DFS for patients receiving reduced-intensity transplants was comparable: 39% for HLA-identical sibling donors and 17% for unrelated donors at 3 years. In this large retrospective series, allogeneic transplantation for myelofibrosis resulted in long-term RFS in about one-third of patients.

Gupta et al reported better DFS rates in a 2014 analysis of 233 patients with primary myelofibrosis who underwent RIC HSCT from 1997 to 2010. Five-year OS was 47% (95% CI, 40% to 53%). Conditioning regimen was not significantly associated with OS.

In another relatively large study that included patients with primary myelofibrosis who were under 65 years old at diagnosis, Kroger et al compared outcomes for patients treated with allo-HSCT (n=190) or conventional therapies (n=248) at diagnosis. In the HSCT group, 91 and 97 subjects received RIC and MA conditioning, respectively. Patients at low risk based on the Dynamic International Prognostic Scoring System model treated with HSCT had a relative risk of death, compared with conventionally treated patients, of 5.6 (95% CI, 1.7 to 19; p=0.005). In contrast, those with intermediate-2 and high risk treated with HSCT had a relative risk of death, compared with conventionally treated patients, of 0.55 (95% CI, 0.36 to 0.83; p=0.005) and 0.37 (95% CI, 0.21 to 0.66; p<0.001), respectively. Intermediate-1 patients treated with HSCT did not significantly differ in risk of death from those treated with conventional therapies. Although the study design was limited by the potential for bias due to patient selection, these results support using prognosis to guide decisions about HSCT for primary myelofibrosis.

The significant toxicity of MA conditioning and allo-HSCT in MPN has led to study of RIC regimens for these diseases. Data from direct, prospective comparison of outcomes of MA conditioning and allo-HSCT versus RIC and allogeneic stem cell support in MPN are not available, but single-arm series and nonrandomized comparative studies report outcomes after RIC allo-HSCT. One series included 27 patients (mean age, 59 years) with MPN who underwent allo-HSCT using an RIC regimen of low-dose (2 Gy) total body irradiation alone or with the addition of fludarabine. At a median follow-up of 47 months, the 3-year RFS was 37%, and OS was 43%, with a 3-year NRM of 32%. In a second series, 103 patients (median age, 55 years; range, 32-68 years) with intermediate-to-high risk (86% of total patients) primary myelofibrosis or postessential thrombocythemia and polycythemia vera myelofibrosis were included in a prospective, multicenter, phase 2 trial to determine efficacy of a busulfan plus fludarabine-based RIC
regimen followed by allo-HSCT from related (n=33) or unrelated (n=70) donors. (43) Acute grade II-IV GVHD occurred in 27% of patients, and chronic GVHD in 43%. The cumulative incidence of NRM at 1 year in all patients was 16% (95% CI, 9% to 23%), but reached 38% (95% CI, 15% to 61%) among those with a mismatched donor versus 12% (95% CI, 5% to 19%) among cases with a matched donor (p=0.003). The cumulative relapse rates at 3 and 5 years were 22% (95% CI, 13% to 31%) and 29% (95% CI, 16% to 42%), respectively. After a median follow-up of 33 months (range, 12-76 months) 5-year estimated DFS and OS were 51% (95% CI, 38% to 64%) and 67% (95% CI, 55% to 79%), respectively.

A 2009 retrospective study analyzed the impact of conditioning intensity on outcomes of allo-HSCT in patients with myelofibrosis. (44) This multicenter trial included 46 consecutive patients treated at 3 Canadian and 4 European transplant centers between 1998 and 2005. Twenty-three patients (median age, 47 years; range, 31-60 years) underwent MA conditioning, and 23 patients (median age, 54 years; range, 38-74 years) underwent RIC. The majority in both groups (85%) were deemed intermediate- or high-risk. At a median follow-up of 50 months (range, 20-89 months), there was a trend for better PFS at 3 years in RIC patients than in MA-conditioned patients (58%; range, 23%-62% vs 43%; range, 35%-76%, respectively; p=0.11); there was a similar trend in 3-year OS (68%; range, 45%-84% vs 48%; range, 27%-66%, respectively; p=0.08). NRM rates at 3 years trended higher in MA-conditioned cases than in RIC cases (48%; range, 31%-74% vs 27%; range, 14%-55%, respectively; p=0.08). The results of this study suggested that both types of conditioning regimens have curative potential in patients with myelofibrosis. Despite the RIC patients being significantly older with longer disease duration and poorer performance status than those who received conventional conditioning, the groups had similar outcomes, supporting the use of RIC allo-HSCT in this population.

In a retrospective study in 9 Nordic transplant centers, a total of 92 patients with myelofibrosis in chronic phase underwent allo-HSCT. (45) MA conditioning was given to 40 patients, and RIC was used in 52 patients. Mean age in the 2 groups at transplantation was 46±12 and 55±8 years, respectively (p<0.001). When adjustment for age differences was made, the survival of the patients treated with RIC was significantly better (p=0.003). Among the RIC patients, survival was significantly (p=0.003) greater for patients younger than age 60 years (a 10-year survival close to 80%) than for patients older than 60 years. The stem cell source did not significantly affect survival. No significant difference was found in NRM at 100 days between the MA- and the RIC-treated patients. The probability of survival at 5 years was 49% for the MA-treated patients and 59% in the RIC group (p=0.125). Patients treated with RIC experienced significantly less acute GVHD than in patients treated with MA conditioning (p<0.001). The OS at 5 years was 70%, 59% and 41% for patients with Lille scores 0, 1, and 2, respectively (p=0.038, when age adjustment was made). Twenty-one percent of patients in the RIC group were given donor lymphocyte infusion because of incomplete donor chimerism, compared with none of the MA-treated patients (p<0.002). Nine percent of patients needed a second transplant because of graft failure,
progressive disease or transformation to AML, with no significant difference between the groups.

**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

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT01366612</td>
<td>PRO#1278: A Phase III Study of Fludarabine and Busulfan Versus Fludarabine, Busulfan and Low Dose Total Body Irradiation in Patients Receiving an Allogeneic Hematopoietic Stem Cell Transplant</td>
<td>54</td>
<td>Dec 2015 (active)</td>
</tr>
<tr>
<td>NCT00176930</td>
<td>Allogeneic Transplant for Hematological Malignancy</td>
<td>350</td>
<td>Dec 2016</td>
</tr>
<tr>
<td>NCT00887068</td>
<td>Randomized Controlled Study of Post-transplant Azacitidine for Prevention of Acute Myelogenous Leukemia and Myelodysplastic Syndrome Relapse</td>
<td>246</td>
<td>Apr 2017</td>
</tr>
<tr>
<td>NCT01471444a</td>
<td>A Randomized Study of Once Daily Fludarabine-Clofarabine Versus Fludarabine Alone Combined With Intravenous Busulfan Followed by Allogeneic Hematopoietic Stem Cell Transplantation for Acute Myeloid Leukemia (AML) and Myelodysplastic Syndrome (MDS)</td>
<td>250</td>
<td>Nov 2017</td>
</tr>
<tr>
<td>NCT00619879</td>
<td>Myeloablative Hematopoietic Progenitor Cell Transplantation (HPCT) for Pediatric Malignancies</td>
<td>200</td>
<td>Jan 2020</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.
a Denotes industry-sponsored or cosponsored trial.

### Summary of Evidence
The evidence for use of myeloablative conditioning allogeneic hematopoietic stem cell transplantation (allo-HSCT) in individuals who have myelodysplastic syndromes (MDS) and myeloproliferative neoplasms (MPN) includes case series of patients, which are often heterogeneous in terms of diseases included. Relevant outcomes are overall survival, disease-specific survival, and treatment-related morbidity and mortality. Primarily uncontrolled, observational studies of HSCT for MDS report a relatively large range of overall and progression-free survival values, which reflects the heterogeneity in patient populations, conditioning regimens, and other factors. Reported estimates for 3- to 5-year overall survival of approximately 40% to 50% are typical. For HSCT for MPN, data are more limited. At least 1 comparative study of HSCT for myelofibrosis demonstrated improved survival with HSCT compared with standard therapy.

The evidence for use of reduced-intensity conditioning (RIC) allo-HSCT in individuals who have MDS and MPN includes primarily retrospective observational series. Relevant outcomes are overall survival, disease-specific survival, and treatment-related morbidity and mortality. Direct, prospective comparisons of outcomes after HSCT with either myeloablative conditioning or RIC in either MDS or MPN are not available. Evidence from retrospective nonrandomized comparisons suggests that RIC may be used in patients who are older and with more
comorbidities without significantly worsening overall survival. RIC appears to be associated with lower rates of nonrelapse mortality but higher cancer relapse than myeloablative HSCT.

SUPPLEMENTAL INFORMATION

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 2 academic medical center specialists prior to review for May 2009. There was consensus among reviewers that RIC allo-HSCT was of value in patients with MDS or MPN who would be medically unable to tolerate a myeloablative HSCT.

Practice Guidelines and Position Statements

National Comprehensive Cancer Network Guidelines
The 2016 National Comprehensive Cancer Network (NCCN) clinical practice guideline for myelodysplastic syndromes (v.1.2016) makes the following recommendation about HSCT in general(46):

“For patients who are transplant candidates, the first choice of a donor has remained an HLA [human leukocyte antigen]-matched sibling, although results with HLA-matched unrelated donors have improved to levels comparable to those obtained with HLA-matched siblings. With the increasing use of cord blood or HLA-haploidentical related donors, HCT [hematopoietic cell transplantation] has become a viable option for many patients. High-dose conditioning is typically used for younger patients, whereas RIC for HCT is generally the strategy in older individuals.”

Specific NCCN guidelines related to HSCT for MDS are outlined in Table 3.

<table>
<thead>
<tr>
<th>Prognostic Category</th>
<th>Recommendations for HSCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPSS low/intermediate-1 OR IPSS-R very low, low, intermediate OR WPSS very low, low, intermediate OR</td>
<td>- Consider allo-HSCT for selected IPSS-1 patients who have clinically relevant thrombocytopenia or neutropenia or increased marrow blasts, with disease progression after azacitidine/decitabine or immunosuppressive therapy for selected patients or clinical trial</td>
</tr>
</tbody>
</table>
response to immunosuppressive therapy, and no response or intolerance to azacitidine/decitabine or immunosuppressive therapy for selected patients or clinical trial

| IPSS intermediate-2, high OR IPSS-R intermediate, high, very high OR WPSS high, very high | Recommend allo-HSCT if a high-intensity therapy candidate and transplant candidate and donor available |


**European Blood and Marrow Transplantation Group and European LeukemiaNet**

In 2015, an expert panel convened by the European Blood and Marrow Transplantation and European LeukemiaNet Group published recommendations for the use of allo-HSCT in primary myelofibrosis and for pre- and posttransplant management and donor selection.(47) Recommendations related to the selectin of patients for allo-HSCT include:

- “All patients with intermediate-2 or high-risk disease according to IPSS, DIPSS [Dynamic International Prognostic Scoring System], or DIPSS+, and age < 70 years, should be considered potential candidates for allo-SCT [stem cell transplant].”
- “Patients with intermediate-1-risk disease and age < 65 years should be considered candidates for allo-SCT if they present with either refractory, transfusion-dependent anemia or a percentage of blasts in PB [peripheral blood] >2%, or adverse cytogenetics (as defined by the DIPSS+ classification).”
- “Patients with low-risk disease should not undergo allo-SCT. They should be monitored and evaluated for transplantation when disease progression occurs.”
- “Patients in blast transformation (blasts in PB or in BM [bone marrow] or both equal to or >20%) are not good candidates for allo-SCT. They should receive debulking therapy and be reconsidered for transplant after achieving a partial or complete remission of leukemia.”
- “Although the use of molecular risk classification for the identification of candidates for allo-SCT among intermediate-1- risk patients deserves further clinical validation, patients in this risk category who are triple negative (that is, JAKV617F, CALR, and MPL negative) or ASXL1 positive, or both, should be considered for allo-SCT.”

**U.S. Preventive Services Task Force Recommendations**

Not applicable.

**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.

**References:**

1. Schanz J, Tuchler H, Sole F, et al. New comprehensive cytogenetic scoring system for primary myelodysplastic syndromes (MDS) and oligoblastic acute myeloid leukemia after MDS derived...


**Billing Coding/Physician Documentation Information**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>38204</td>
<td>Management of recipient hematopoietic progenitor cell donor search and cell acquisition</td>
</tr>
<tr>
<td>38205</td>
<td>Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic</td>
</tr>
<tr>
<td>38208</td>
<td>Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing</td>
</tr>
<tr>
<td>38209</td>
<td>Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing</td>
</tr>
<tr>
<td>38210</td>
<td>Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion</td>
</tr>
<tr>
<td>38211</td>
<td>Transplant preparation of hematopoietic progenitor cells; tumor cell depletion</td>
</tr>
<tr>
<td>38212</td>
<td>Transplant preparation of hematopoietic progenitor cells; red blood cell removal</td>
</tr>
<tr>
<td>38213</td>
<td>Transplant preparation of hematopoietic progenitor cells; platelet</td>
</tr>
</tbody>
</table>
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 Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic

86812 HLA typing; A, B, or C (eg, A10, B7, B27), single antigen
86813 HLA typing; A, B, or C, multiple antigens
86816 HLA typing; DR/DQ, single antigen
86817 HLA typing; DR/DQ, multiple antigens
86821 HLA typing; lymphocyte culture, mixed (MLC)
86822 HLA typing; lymphocyte culture, primed (PLC)
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 services; and the number of days of pre- and post-transplant care in the global definition

ICD-10 Codes
C92.10- C92.12 Chronic myeloid leukemia, BCR/ABL-positive code range
C92.20- C92.22 Atypical chronic myeloid leukemia, BCR/ABL-negative code range
C94.6  Myelodysplastic disease, not classified
Myeloproliferative disease, not classified
D45  Polycythemia vera
D46.0- D46.9 Myelodysplastic syndromes code range
D47.0- D47.9 Other neoplasms of uncertain behavior of lymphoid, hematopoietic and related tissue code range

Additional Policy Key Words
N/A

Policy Implementation/Update Information
12/1/01 New policy. Added to Surgery and Lab sections.
12/1/02 No policy statement change. Added new codes
12/1/03 No policy statement change.
12/1/05 No policy statement change. Removed from Lab section.
4/1/06 Considerations section revised to include general criteria.
12/1/06 No policy statement changes.
12/1/07  No policy statement changes.
12/1/08  “Myeloproliferative” added and “High-Dose Chemotherapy” removed from policy title and policy statements reworded, but the policy statements remain otherwise unchanged
12/1/09  Policy statements revised to indicate that RIC HSCT may be considered medically necessary as a treatment of myelodysplastic syndrome and myeloproliferative neoplasms in patients who for medical reasons would be unable to tolerate a myeloablative conditioning regimen. Term “Myeloproliferative Disorders” replaced with “Myeloproliferative Neoplasms” in title and text.
12/1/10  No policy statement changes.
12/1/11  No policy statement changes.
1/1/12   Coding updated.
12/1/12  No policy statement changes.
12/1/13  Minor changes in the description. Added to title name. No policy statement changes.
1/1/15   Reworded parts of policy statement, does not change the intent of the policy.
1/1/15   No policy statement changes.
1/1/16   No policy statement changes.

State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.