Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia

**POLICY**

Allogeneic hematopoietic cell transplantation (HCT) using a myeloablative conditioning regimen may be considered medically necessary as a treatment of chronic myeloid leukemia.

Allogeneic HCT using a reduced-intensity conditioning regimen may be considered medically necessary as a treatment of chronic myeloid leukemia in patients who meet clinical criteria for an allogeneic HCT but who are not considered candidates for a myeloablative conditioning allogeneic HCT.

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

**POLICY GUIDELINES**

Some patients for whom a conventional myeloablative allotransplant could be curative may be considered candidates for reduced-intensity conditioning allogeneic hematopoietic cell transplantation. They include those patients whose age (typically >60 years) or comorbidities (e.g., liver or kidney...
dysfunction, generalized debilitation, prior intensive chemotherapy, low Karnofsky Performance Status score) preclude use of a standard myeloablative conditioning regimen.

For patients who qualify for a myeloablative allogeneic hematopoietic cell transplantation on the basis of clinical status, either a myeloablative or a reduced-intensity conditioning regimen may be considered medically necessary.

**BENEFIT APPLICATION**

**BLUECARD/NATIONAL ACCOUNT ISSUES**

The following considerations may supersede this policy:

- State mandates requiring coverage for autologous bone marrow transplantation offered as part of clinical trials of autologous bone marrow transplantation approved by the National Institutes of Health.
- Some plans may participate in voluntary programs offering coverage for patients participating in National Institutes of Health–approved clinical trials of cancer chemotherapies, including autologous bone marrow transplantation.
- Some contracts or certificates of coverage (e.g., Federal Employee Program) may include specific conditions in which autologous bone marrow transplantation would be considered eligible for coverage.

**BACKGROUND**

**Chronic Myeloid Leukemia**

CML is a hematopoietic stem cell disorder characterized by the presence of a chromosomal abnormality called the Philadelphia chromosome, which results from a reciprocal translocation between the long arms of chromosomes 9 and 22. This cytogenetic change results in constitutive activation of the fusion gene BCR-ABL, a tyrosine kinase that stimulates unregulated cell proliferation, inhibits cell apoptosis, creates genetic instability, and upsets interactions between CML cells and the bone marrow stroma only in malignant cells. CML accounts for about 15% of newly diagnosed cases of leukemia in adults and occurs in 1 to 2 cases per 100000 adults.¹

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

**Treatment**

Historically, the only curative therapy for CML in blast phase has been allogeneic hematopoietic cell transplantation (allo-HCT), which was used more widely earlier in the disease process given the lack of other therapies for chronic phase CML. Drug therapies for chronic phase CML were limited to nonspecific agents including busulfan, hydroxyurea, and interferon-α.²

Imatinib mesylate (Gleevec®), a selective inhibitor of the abnormal BCR-ABL tyrosine kinase protein, is considered the treatment of choice for newly diagnosed CML. While imatinib can be highly effective in
suppressing CML, it is not curative and is ineffective in 20% to 30% of patients, initially or due to development of BCR-ABL variants that cause resistance to the drug. Even so, the overall survival of patients who present in the chronic phase is greater than 95% at 2 years and 80% to 90% at 5 years. For CML, two other tyrosine kinase inhibitors ([TKIs]; dasatinib, nilotinib) have received marketing approval from the U.S. Food and Drug Administration as first-line therapies or following failure or patient intolerance of imatinib. Two additional TKIs (bosutinib, ponatinib) have been approved for use in patients resistant or intolerant to prior therapy. For patients on imatinib who have disease progression, the therapeutic options include increasing the imatinib dose, changing to another TKI, or allo-HCT. Detection of BCR-ABL variants may be important in determining an alternative TKI; the presence of the T315I variant is associated with resistance to all TKIs and should indicate the need for allo-HCT or experimental therapy. TKIs have been associated with long-term remissions; however, if disease progression occurs on TKI therapy, allo-HCT is generally indicated and offers the potential for cure.

Hematopoietic Cell Transplantation

HCT is a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone-marrow-toxic doses of drugs with or without whole body radiotherapy. Hematopoietic stem cells may be obtained from the transplant recipient (autologous HCT) or a donor (allo-HCT). They can be harvested from bone marrow, peripheral blood, or umbilical cord blood shortly after delivery of neonates. Although cord blood is an allogeneic source, the stem cells in it are antigenically “naive” and thus are associated with a lower incidence of rejection or graft-versus-host disease (GVHD). Cord blood is discussed in detail in evidence review 7.01.50.

Immunologic compatibility between infused hematopoietic stem cells and the recipient is not an issue in autologous HCT. However, immunologic compatibility between donor and patient is critical for achieving a good outcome with allo-HCT. Compatibility is established by typing of human leukocyte antigens (HLAs) using cellular, serologic, or molecular techniques. HLA refers to the tissue type expressed at the HLA-A, -B, and -DR loci on each arm of chromosome 6. Depending on the disease being treated, an acceptable donor will match the patient at all or most of the HLA loci (except umbilical cord blood).

Conventional Conditioning for HCT

The conventional practice of allo-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 of this procedure is due to a combination of initial eradication of malignant cells and subsequent graft-versus-malignancy (GVM) effect that is mediated by non-self-immunologic effector cells that develop after engraftment of allogeneic stem cells within the patient’s bone marrow space. While the slower GVM effect is considered 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 allo-HCT, immunosuppressant drugs are required to minimize graft rejection and GVHD, which also increase susceptibility to opportunistic infections. The immune reactivity between donor T cells and malignant cells that is responsible for the GVM effect also leads to acute and chronic GVHD.

The success of autologous HCT is predicated on the ability of cytotoxic chemotherapy with or without radiation to eradicate cancerous cells from the blood and bone marrow. This permits subsequent
engraftment and repopulation of bone marrow space with presumably normal hematopoietic stem cells obtained from the patient before undergoing bone marrow ablation. As a consequence, autologous HCT is typically performed when the patient’s disease is in complete remission. Patients who undergo autologous HCT are susceptible to chemotherapy-related toxicities and opportunistic infections before engraftment, but not GVHD.

**Reduced-Intensity Conditioning for Allo-HCT**

RIC refers to the pretransplant use of lower doses or less intense regimens of cytotoxic drugs or radiotherapy 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 nonrelapse mortality 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 nonrelapse mortality and relapse due to residual disease. RIC regimens can be viewed as a continuum in effects, from near totally myeloablative, to minimally myeloablative with lymphoablation, with intensity tailored to specific diseases and patient condition. Patients who undergo RIC with allo-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 this evidence review, RIC will refer to all conditioning regimens intended to be nonmyeloablative, as opposed to fully myeloablative (conventional) regimens.

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

**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.

**RATIONALE**

This evidence review was created in December 1999 and has been updated regularly with searches of the MEDLINE database. The most recent literature update was performed through December 21, 2018.

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life, and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, two domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend
on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice. The following is a summary of the key literature to date.

**Allogeneic Hematopoietic Cell Transplantation**

**Clinical Context and Test Purpose**

The purpose of allo-HCT is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with chronic myeloid leukemia (CML).

The question addressed in this evidence review is: does the use of allo-HCT improve the net health outcomes of individuals with CML?

The following PICOTS were used to select literature to inform this review.

**Patients**

The relevant population of interest are patients with CML.

**Interventions**

The therapy being considered is allo-HCT.

**Comparators**

Comparators of interest include cytotoxic chemotherapy and treatment with tyrosine kinase inhibitors (TKIs).

**Outcomes**

The general outcomes of interest are overall survival (OS), disease-specific survival, treatment-related mortality, and treatment-related morbidity.

**Timing**

Follow-up over months to years is of interest for relevant outcomes.

**Setting**

Patients are actively managed by hematologists/oncologists in an inpatient and outpatient clinical setting.

**Study Selection Criteria**

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

In the pre-TKI era, allo-HCT was the standard of care for CML. Evidence in support of allo-HCT includes a 2015 RCT comparing primary HCT from a matched family donor (n=166) with best available drug
treatment (n=261), which enrolled patients from 1997 to 2004. There were no differences in 10-year OS between groups (0.76 for HCT patients vs 0.69 for drug treatment patients). Those with low transplant risk treated with HCT had improved survival compared with those treated with medical therapy, but, after patients entered the blast crisis, survival did not differ between groups.

The advent of TKI therapy has altered the treatment paradigm for CML such that most patients are treated initially with a TKI until the disease progresses. While progression may occur within months of starting a TKI, progression may be delayed for years, as shown by the results of the International Randomized Study of Interferon and STI571 trial and other studies. With the addition of three other TKIs (nilotinib, dasatinib, bosutinib) plus the possibility of effective dose escalation with imatinib to override resistance, it is possible to maintain a typical CML patient past the upper age limit (usually 50-55 years) at which a myeloablative allo-HCT is considered an option.

**Nonrandomized Studies**

Several nonrandomized studies have compared treatment using TKI therapy with allo-HCT in CML patients. Liu et al (2013) evaluated outcomes for CML patients who underwent HCT after imatinib failure. They retrospectively evaluated 105 patients with newly diagnosed chronic phase CML seen at a single institution from 1999 to 2011. Sixty-six patients received first-line imatinib therapy, 26 (treated before 2003) received interferon followed by imatinib, and 13 received first-line allo-HCT with curative intent. Twenty-two (21%) patients received allo-HCT overall, including 13 as first-line therapy and 9 following imatinib failure. Compared with those who received first-line allo-HCT, those who underwent HCT following imatinib failure had higher European Group for Blood and Marrow Transplantation risk score (p=0.03). Among those receiving allo-HCT (n=22; median follow-up, 134 months; range, 6-167 months), patients with imatinib failure and disease progression had a significantly worse OS (p=0.015) compared with those receiving allo-HCT as first-line therapy. Patients receiving first-line allo-HCT had a 3-year OS rate of 91.7% (95% confidence interval, 29 to 38 months); 1 patient in this group died of relapse and 1 of chronic graft-versus-host disease.

Xu et al (2015) retrospectively compared second-generation TKI therapy with allo-HCT in 93 patients in accelerated phase CML. The second-generation TKI therapy group included 33 subjects, most of whom had been previously treated with another TKI (31 with imatinib, 2 with nilotinib). Of 60 patients treated with allo-HCT, 10 were treated with HCT for the first time, and 50 had been previously treated with imatinib. Median OS was significantly shorter with second-generation TKI treatment (22 months) than with allo-HCT (82 months). Median progression-free survival and event-free survival rates were similarly shorter with second-generation TKI treatment than with allo-HCT.

Zhang et al (2016) retrospectively compared imatinib (n=292) with allo-HCT (n=141) in patients who had CML. Survival rates were significantly longer in the imatinib group than in the allo-HCT group: 5-year EFS rates were 84% and 75% (p<0.05) and 5-year OS rates were 92% and 79%, both respectively. Findings were similar for patients with chronic phase and advanced phase disease.

Several studies have compared outcomes for CML patients treated with allo-HCT in the pre- and current TKI eras. While these studies have generally reported no worsening in treatment outcomes for allo-HCT following TKI therapy, they are limited by their underlying differences in treatment regimens from different eras. In a retrospective analysis by Shen et al (2015), of the 106 patients who underwent allo-HCT and who either did (n=36) or did not (n=70) receive prior treatment with TKIs, no significant differences were reported in 10-year relapse-free survival or OS rates. However, TKI-treated patients had a higher incidence of 0.5-year transplant-related mortality. In another retrospective analysis comparing patients treated using allo-HCT in the pre-TKI era (1989-2001; n=39) with those treated in the
TKI era (2002-2013; n=30), Chamseddine et al (2015) reported longer 3-year OS and leukemia-free survival among patients treated in the TKI era.13

Case Series
A number of case series, primarily involving a single-center, have reported outcomes for patients treated with allo-HCT following TKI treatment failure. In a 2015 series of 51 patients given allo-HCT, 32 of whom were treated for TKI resistance or intolerance, 8-year OS and event-free survival rates were 68% and 46%, respectively.14 Another 2015 prospective series of 28 patients who underwent allo-HCT after the failure of at least 2 TKIs, reported deep molecular remission in 18 subjects.15 However, all six patients transplanted in blast crisis died. In a smaller series, Zhao et al (2014) reported on outcomes for 12 patients with CML who experienced disease progression on imatinib and received dasatinib or nilotinib followed by allo-HCT at a single-center.16 After a median follow-up of 28 months (range, 12-37 months) after allo-HCT, 8 (66.7%) of 12 patients were alive, including 7 with complete molecular remission.

In addition to being used prior to allo-HCT, TKI therapy may be used after HCT to prevent or treat disease relapse. Egan et al (2015) retrospectively analyzed patients at a single institution who underwent allo-HCT for CML and Philadelphia chromosome-positive acute lymphoblastic leukemia and had detectable BCR-ABL transcripts by polymerase chain reaction, as well as RNA available for sequencing of the ABL kinase domain, in both the pre- and post-HCT settings to evaluate the impact of pre-HCT variants in the ABL kinase domain on post-HCT relapse.12 Among 95 patients with CML with available polymerase chain reaction transcripts, 10 (10.5%) were found to have pre-HCT ABL kinase variants known to confer resistance to TKIs. Of those with CML, 88.4% underwent myeloablative chemotherapy, and 11.6% underwent nonmyeloablative chemotherapy. Twenty-nine CML patients received post-HCT TKI therapy for prophylaxis and 10 (34.5%) for treatment of refractory or relapsed disease. In 9 (64.2%) of the 14 patients with pre-HCT variants (which included both CML and Philadelphia chromosome-positive acute lymphoblastic leukemia), the same variants conferring TKI resistance was also detectable after allo-HCT. Among the 14 with pre-HCT variants, 8 (57.1%) received a TKI in the post-HCT setting, and 7 (50%) demonstrated post-HCT refractory disease or relapse. Of the 7 with relapsed disease, 6 had been given a predictably ineffective TKI within the first 100 days after allo-HCT, based on variant analysis conducted by the authors.

HCT With Nonmyeloablative Conditioning
Techniques for allo-HCT have continued to develop, with important advancements in the use of nonmyeloablative or reduced-intensity conditioning (RIC) preparative regimens. Overall, among 9 studies evaluated in a 2007 review, outcomes with RIC allogeneic transplants were similar to those with conventional allotransplants, with OS rates ranging from 35% at 2.5 years to 85% at 5 years among patients in chronic phase at transplant.16 Among the studies assessed in this review, treatment-related mortality or nonrelapse mortality ranged from 0% to 29% at 1 year. In the largest retrospective study, the European Group for Blood and Marrow Transplantation (2005) evaluated 186 patients.16 The OS rate was 54% at 3 years using a variety of RIC regimens in patients in chronic phase 1 (n=118), chronic phase 2 (n=26), acute phase (n=30), and blast crisis (n=12). Among patients transplanted in the first chronic phase, the OS rate was 69% at 3 years.

RIC regimens have many of the same limitations as standard-intensity conditioning: relapse, graft-versus-host disease, and mortality from treatment-related causes other than myelotoxicity. However, in the absence of prospective, comparative, randomized trials, only indirect comparisons can be made between the relative clinical benefits and harms associated with myeloablative and RIC regimens with allo-HCT. Comparison of study results is further complicated by heterogeneity across patients,
treatments, and outcome measures. Nonetheless, clinical evidence has suggested outcomes in CML are similar between myeloablative and RIC allo-HCT.\(^5\,18\,19\).

**Section Summary: Allo-HCT**

Allo-HCT is accepted as a standard treatment in CML, although the use of targeted TKI therapy has allowed many patients who would previously have required allo-HCT to forstall or avoid transplantation altogether. Direct comparisons between myeloablative and nonmyeloablative RIC regimens are not available, but the available evidence has suggested that allo-HCT following nonmyeloablative conditioning regimens can lead to short- and medium-term survival rates that are on the order of those seen after myeloablative conditioning regimens. Although research into the optimal timing of allo-HCT in the setting of TKI therapy is limited, the available evidence has suggested that pretreatment with TKIs does not worsen outcomes after allo-HCT and may improve outcomes.

**Autologous HCT**

**Clinical Context and Test Purpose**

The purpose of autologous HCT is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with CML.

The question addressed in this evidence review is: does the use of autologous HCT improve the net health outcomes of individuals with CML?

The following PICOTS were used to select literature to inform this review.

**Patients**

The relevant population of interest are patients with CML.

**Interventions**

The therapy being considered is autologous HCT.

**Comparators**

Comparators of interest include cytotoxic chemotherapy and treatment with TKIs.

**Outcomes**

The general outcomes of interest are OS, disease-specific survival, treatment-related mortality, and treatment-related morbidity.

**Timing**

Follow-up over months to years is of interest for relevant outcomes.

**Setting**

Patients are actively managed by hematologists/oncologists in an inpatient and outpatient clinical setting.

**Study Selection Criteria**

Methodologically credible studies were selected using principles described above.

A major limitation in the use of autologous HCT in patients with CML is a high probability that leukemic cells will be infused back into the patient. However, it is recognized that many CML patients still have normal marrow stem cells. Techniques used to isolate and expand this normal clone of cells have included ex vivo purging, long-term culture, and immunophenotype selection.\(^20\) Even without such
techniques, there are isolated case reports of partial cytogenetic remissions after autologous HCT, and a 1997 study suggested that patients undergoing such therapy may have improved survival compared with historical controls.21

In the pre-TKI era, there was active research into the use of autologous HCT for CML. McGlave et al (1994) reported on outcomes for 200 consecutive autologous transplants using purged or unpurged marrow from 8 different transplant centers over 7 years.22 Of the 200 patients studied, 125 were alive at a median follow-up of 42 months. Of the 142 transplanted in chronic phase, median survival had not been reached at the time of publication, while the median survival was 35.9 months for those transplanted during an accelerated phase. Other data consist of a small, single institution case series using a variety of techniques to enrich the population of normal stem cells among the harvested cells.21

Additional reports of small, uncontrolled studies with a total of 182 patients (range, 15-41 patients) given autologous HCT for CML included patient populations that varied across the studies. Some (2000, 2001) focused on newly diagnosed patients or those in the first year since diagnosis.23,24 Others (1999, 2000) have focused on patients who did not respond to or relapsed after initial treatment using interferon alfa.25,26 Finally, some have focused on patients transplanted in the late chronic phase (2000)27 or after transformation to accelerated phase or blast crisis (1999).28 Although some patients achieved complete or partial molecular remission and long-term disease-free survival, these studies do not permit conclusions free from the influence of selection bias. All autotransplanted patients included in these reports were treated before imatinib mesylate, or newer TKIs became available.

**Section Summary: Autologous HCT**

No controlled studies have evaluated autologous HCT for treatment of CML. The available data consists of case reports and case series. In the largest series (n=200 patients), median survival was 36 months for patients transplanted during an accelerated phase and median survival data were not available for patients transplanted in chronic phase. Controlled studies are needed to permit conclusions about the impact of autologous HCT on health outcomes in patients with CML.

**Summary of Evidence**

For individuals who have CML who receive allo-HCT, the evidence includes systematic reviews, RCTs, and multiple prospective and retrospective series. The relevant outcomes are OS, disease-specific survival, and treatment-related morbidity and mortality. The introduction of TKIs has significantly changed the clinical use of HCT for CML. TKIs have replaced HCT as initial therapy for patients with chronic phase CML. However, a significant proportion of cases fail to respond to TKIs, develops resistance to them, or cannot tolerate TKIs and proceed to allo-HCT. Also, allo-HCT represents the only potentially curative option for those patients in the accelerated or blast phase CML. Currently, available evidence has suggested that TKI pretreatment does not lead to worse outcomes if HCT is needed. Myeloablative conditioning regimens before HCT are used in younger (<60 years) patients without significant comorbidities. However, for patients with more comorbidities and/or more advanced age for whom myeloablative conditioning regimens would be prohibitively high-risk, evidence has suggested that reasonable outcomes can be obtained after HCT. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

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

**SUPPLEMENTAL INFORMATION**

**Practice Guidelines and Position Statements**

**National Comprehensive Cancer Network**

Current National Comprehensive Cancer Network guidelines (v.1.2019) recommend allogeneic hematopoietic cell transplantation (allo-HCT) as an alternative treatment only for high-risk settings or in patients with advanced phase chronic myeloid leukemia (CML). Relevant recommendations are:

- “Allogeneic HCT is no longer recommended as a first-line treatment option for CP [chronic phase] CML.”
- “Allogeneic HCT is an appropriate treatment option for the very rare patients presenting with BP [blast phase]-CML at diagnosis, patients with disease that is resistant to TKIs, patients with progression to AP [accelerated phase]-CML or BP-CML while on TKI therapy, and for the rare patients intolerant to all TKIs”
- “Evaluation for allogeneic HCT….is recommended for all patients with AP-CML or BP-CML”

The Network guidelines also state: “Nonmyeloablative allogeneic HCT is a well-tolerated treatment option for patients with a matched donor and the selection of patients is based on their age and the presence of comorbidities.”

Autologous HCT for CML is not addressed in these guidelines.

**American Society for Blood and Marrow Transplantation**

The guidelines by the American Society for Blood and Marrow Transplantation (2015) addressed indications for autologous and allo-HCT for CML. Recommendations are listed in Table 1.

**Table 1. Recommendations on Allogeneic and Autologous HCT for CML**

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<thead>
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<th>Indications</th>
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MP 8.01.30
Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia

C: standard of care, clinical evidence available, CML: chronic myeloid leukemia; HCT: hematopoietic cell transplantation; N: not generally recommended; S: standard of care.

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

Not applicable.

**Medicare National Coverage**

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

**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**

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<td>NCT00036738</td>
<td>Fludarabine Phosphate and Total-Body Irradiation Followed by Donor Peripheral Blood Stem Cell Transplant in Treating Patients with Acute Lymphoblastic Leukemia or Chronic Myelogenous Leukemia That Has Responded to Treatment with Imatinib Mesylate, Desatinib, or Nilotinib</td>
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<td>NCT00709592</td>
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NCT: national clinical trial.

**ESSENTIAL HEALTH BENEFITS**

The Affordable Care Act (ACA) requires fully insured non-grandfathered individual and small group benefit plans to provide coverage for ten categories of Essential Health Benefits (“EHBs”), whether the benefit plans are offered through an Exchange or not. States can define EHBs for their respective state.

States vary on how they define the term small group. In Idaho, a small group employer is defined as an employer with at least two but no more than fifty eligible employees on the first day of the plan or contract year, the majority of whom are employed in Idaho. Large group employers, whether they are self-funded or fully insured, are not required to offer EHBs, but may voluntary offer them.

The Affordable Care Act requires any benefit plan offering EHBs to remove all dollar limits for EHBs.

**REFERENCES**


CODES

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Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia

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<tr>
<td>38208</td>
<td>Thawing of previously frozen harvest, without washing, per donor</td>
</tr>
<tr>
<td>38209</td>
<td>Thawing of previously frozen harvest, with washing, per donor</td>
</tr>
<tr>
<td>38210</td>
<td>Specific cell depletion within harvest, T-cell depletion</td>
</tr>
<tr>
<td>38211</td>
<td>Tumor cell depletion</td>
</tr>
<tr>
<td>38212</td>
<td>Red blood cell removal</td>
</tr>
<tr>
<td>38213</td>
<td>Platelet depletion</td>
</tr>
<tr>
<td>38214</td>
<td>Plasma (volume) depletion</td>
</tr>
<tr>
<td>38215</td>
<td>Cell concentration in plasma, mononuclear, or buffy coat layer</td>
</tr>
<tr>
<td>38230</td>
<td>Bone marrow harvesting for transplantation; allogeneic</td>
</tr>
<tr>
<td>38232</td>
<td></td>
</tr>
<tr>
<td>38240</td>
<td>Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor</td>
</tr>
<tr>
<td>38241</td>
<td>Autologous transplantation</td>
</tr>
</tbody>
</table>

**HCPCS**

- Q0083-Q0085 Chemotherapy administration code range
- J9000-J9999 Chemotherapy drug code range
- S2140 Cord blood harvesting for transplantation, allogeneic
- S2142 Cord blood-derived stem-cell transplantation, allogeneic
- S2150 Bone marrow or blood-derived peripheral stem-cell harvesting and transplantation, allogeneic or autologous, including pheresis, high-dose chemotherapy, and the number of days of posttransplant care in the global definition (including drugs; hospitalization; medical surgical, diagnostic, and emergency services)

**ICD-10-CM**

- 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

**ICD-10-PCS**

- Administration, circulatory, transfusion, peripheral vein, percutaneous, autologous, code by substance (bone marrow, cord blood or stem cells, hematopoietic) code list
- Administration, circulatory, transfusion, peripheral vein, percutaneous, allogeneic related, code by substance (bone marrow, cord blood or stem cells, hematopoietic) code list
- Administration, circulatory, transfusion, peripheral vein, percutaneous, allogeneic unrelated, code by substance (bone marrow, cord blood or stem cells, hematopoietic) code list
- Administration, circulatory, transfusion, peripheral vein, percutaneous, allogeneic unspecified, code by substance (bone marrow, cord blood or stem cells, hematopoietic) code list
- Administration, circulatory, transfusion, central vein, percutaneous, autologous, code by substance (bone marrow, cord blood or stem cells, hematopoietic) code list
- Administration, circulatory, transfusion, central vein, percutaneous, allogeneic related, code by substance (bone marrow, cord blood or stem cells, hematopoietic) code list
- Administration, circulatory, transfusion, central vein, percutaneous, allogeneic unrelated, code by substance (bone marrow, cord blood or stem cells, hematopoietic) code list

ICD-10-PCS codes are only used for inpatient services.
### Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia

<table>
<thead>
<tr>
<th>Code List</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>30243G4, 30243X4, 30243Y4</td>
<td>Administration, circulatory, transfusion, central vein, percutaneous, allogeneic unspecified, code by substance (bone marrow, cord blood or stem cells, hematopoietic) code list</td>
</tr>
<tr>
<td>30250G0, 30250X0, 30250Y0</td>
<td>Administration, circulatory, transfusion, peripheral artery, open, autologous, code by substance (bone marrow, cord blood or stem cells, hematopoietic)</td>
</tr>
<tr>
<td>30250G1, 30250X1, 30250Y1</td>
<td>Administration, circulatory, transfusion, peripheral artery, open, nonautologous, code by substance (bone marrow, cord blood or stem cells, hematopoietic)</td>
</tr>
<tr>
<td>30253G0, 30253X0, 30253Y0</td>
<td>Administration, circulatory, transfusion, peripheral artery, percutaneous, autologous, code by substance (bone marrow, cord blood or stem cells, hematopoietic)</td>
</tr>
<tr>
<td>30253G1, 30253X1, 30253Y1</td>
<td>Administration, circulatory, transfusion, peripheral artery, percutaneous, nonautologous, code by substance (bone marrow, cord blood or stem cells, hematopoietic)</td>
</tr>
<tr>
<td>6A550ZT, 6A550ZV</td>
<td>Extracorporeal Therapies, pheresis, circulatory, single, code by substance (cord blood, or stem cells, hematopoietic)</td>
</tr>
<tr>
<td>6A551ZT, 6A551ZV</td>
<td>Extracorporeal Therapies, pheresis, circulatory, multiple, code by substance (cord blood, or stem cells, hematopoietic)</td>
</tr>
</tbody>
</table>

**Type of service:** Therapy  
**Place of service:** Inpatient/Outpatient

### POLICY HISTORY

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/14/16</td>
<td>Replace policy</td>
<td>Policy updated with literature review through October 27, 2015; references 3, 8, 18, and 20-22 added. Policy statements unchanged.</td>
</tr>
<tr>
<td>06/01/17</td>
<td>Replace policy</td>
<td>Policy updated with literature review through November 9, 2016; references 11 and 30 added. In title and policy statements, “stem” removed and “myelogenous” changed to “myeloid”.</td>
</tr>
<tr>
<td>02/26/18</td>
<td>Replace policy</td>
<td>Blue Cross of Idaho adopted changes as noted. Policy updated with literature review through December 11, 2017; no reference added, reference 29 updated. Policy statements unchanged.</td>
</tr>
<tr>
<td>01/24/19</td>
<td>Replace policy</td>
<td>Blue Cross of Idaho adopted changes as noted, effective 01/24/2019. Policy updated with literature review through December 21, 2018; no references added, reference 29 updated. Policy statements unchanged.</td>
</tr>
</tbody>
</table>