Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma

The following Protocol contains medical necessity criteria that apply for this service. It is applicable to Medicare Advantage products unless separate Medicare Advantage criteria are indicated. If the criteria are not met, reimbursement will be denied and the patient cannot be billed. Preauthorization is required and must be obtained through Case Management.* Please note that payment for covered services is subject to eligibility and the limitations noted in the patient’s contract at the time the services are rendered.

Description

Hematopoietic Stem-Cell Transplantation

Hematopoietic stem-cell transplantation (HSCT) refers to a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone-marrow-toxic doses of cytotoxic drugs with or without whole-body radiation therapy. 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).

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 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.

The success of autologous HSCT 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 prior to undergoing bone marrow ablation. As a consequence, autologous HSCT is typically performed as
consolidation therapy when the patient’s disease is in complete remission. Patients who undergo autologous HSCT are susceptible to chemotherapy-related toxicities and opportunistic infections prior to engraftment, but not GVHD.

**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 nonrelapse 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 Protocol, the term “reduced-intensity conditioning” will refer to all conditioning regimens intended to be nonmyeloablative, as opposed to fully myeloablative (conventional) regimens.

**Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma**

Chronic lymphocytic leukemia (CLL) and small lymphocytic lymphoma (SLL) are neoplasms of hematopoietic origin characterized by the accumulation of lymphocytes with a mature, generally well-differentiated morphology. In CLL, these cells accumulate in blood, bone marrow, lymph nodes, and spleen, while in SLL they are generally confined to lymph nodes. The Revised European-American/WHO Classification of Lymphoid Neoplasms considers B-cell CLL and SLL a single disease entity.

CLL and SLL share many common features and are often referred to as blood and tissue counterparts of each other, respectively. Both tend to present as asymptomatic enlargement of the lymph nodes, tend to be indolent in nature, but can undergo transformation to a more aggressive form of disease (e.g., Richter’s transformation). The median age at diagnosis of CLL is approximately 72 years, but it may present in younger individuals, often as poor-risk disease with significantly reduced life expectancy.

Treatment regimens used for CLL are generally the same as those used for SLL, and outcomes of treatment are comparable for the two diseases. Both low- and intermediate-risk CLL and SLL demonstrate relatively good prognoses with median survivals of six to 10 years, while the median survival of high-risk CLL or SLL may only be two years (see Policy Guidelines). Although typically responsive to initial therapy, CLL and SLL are rarely cured by conventional therapy, and nearly all patients ultimately die of their disease. This natural history prompted investigation of hematopoietic stem-cell transplantation as a possible curative regimen.

**Corporate Medical Guideline**

Autologous hematopoietic stem-cell transplantation is considered investigational to treat chronic lymphocytic leukemia or small lymphocytic lymphoma.

Allogeneic hematopoietic stem-cell transplantation is considered medically necessary to treat chronic lymphocytic leukemia or small cell lymphocytic leukemia in patients with markers of poor-risk disease (see Policy Guidelines). Use of a myeloablative or reduced-intensity pretransplant conditioning regimen should be individualized based on factors that include patient age, the presence of comorbidities, and disease burden.
Policy Guideline

Staging and Prognosis of CLL/SLL

Two scoring systems are used to determine stage and prognosis of patients with CLL/SLL. As outlined in the Table 1, the Rai and Binet staging systems classify patients into three risk groups with different prognoses, and are used to make therapeutic decisions.

Table 1. Rai and Binet Classification for CLL/SLL

<table>
<thead>
<tr>
<th>Rai Stage</th>
<th>Risk</th>
<th>Description</th>
<th>Median Survival (yr)</th>
<th>Binet Stage</th>
<th>Description</th>
<th>Median Survival (yr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Low</td>
<td>Lymphocytosis</td>
<td>&gt; 10</td>
<td>A</td>
<td>3 or fewer lymphoid areas, normal hemoglobin and platelets</td>
<td>&gt; 10</td>
</tr>
<tr>
<td>I</td>
<td>Intermediate</td>
<td>Lymphocytosis plus lymphadenopathy</td>
<td>7-9</td>
<td>B</td>
<td>3 or more lymphoid areas, normal hemoglobin and platelets</td>
<td>7</td>
</tr>
<tr>
<td>II</td>
<td>Intermediate</td>
<td>Lymphocytosis plus splenomegaly plus/minus lymphadenopathy</td>
<td>7-9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>High</td>
<td>Lymphocytosis plus anemia plus/minus lymphadenopathy or splenomegaly</td>
<td>1.5-5</td>
<td>C</td>
<td>Any number of lymphoid areas, anemia, thrombocytopenia</td>
<td>5</td>
</tr>
<tr>
<td>IV</td>
<td>High</td>
<td>Lymphocytosis plus thrombocytopenia plus/minus anemia, splenomegaly or lymphadenopathy</td>
<td>1.5-5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

lymphocytosis = lymphocytes > 15 x 10^9/L for 4 wks; anemia = hemoglobin < 110 g/L; thrombocytopenia = platelets < 100 x 10^9/L

Because prognosis of patients varies within the different Rai and Binet classifications, other prognostic markers are used in conjunction with staging to determine clinical management. These are summarized in Table 2, according to availability in clinical centers.

Table 2. Markers of Poor Prognosis in CLL/SLL

<table>
<thead>
<tr>
<th>Community Center</th>
<th>Specialized Center</th>
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</thead>
<tbody>
<tr>
<td>Advanced Rai or Binet stage</td>
<td>IgVh wild type</td>
</tr>
<tr>
<td>Male sex</td>
<td>Expression of ZAP-70 protein</td>
</tr>
<tr>
<td>Atypical morphology or CLL/PLL</td>
<td>del 11q22-q23 (loss of ATM gene)</td>
</tr>
<tr>
<td>Peripheral lymphocyte doubling time &lt; 12 months</td>
<td>del 17p13 (loss of p53) trisomy 12</td>
</tr>
<tr>
<td>CD38+</td>
<td>trisomy 12</td>
</tr>
<tr>
<td>Elevated beta2-microglobulin level</td>
<td>Elevated serum CD23</td>
</tr>
<tr>
<td>Diffuse marrow histology</td>
<td>Elevated serum tumor necrosis factor-a</td>
</tr>
<tr>
<td>Elevated serum lactate dehydrogenase level</td>
<td>Elevated serum thymidine kinase</td>
</tr>
<tr>
<td>Fludarabine resistance</td>
<td></td>
</tr>
</tbody>
</table>

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Reduced-Intensity Conditioning for Allogeneic HSCT

Some patients for whom a conventional myeloablative allotransplant could be curative may be considered candidates for RIC allogeneic HSCT. These include those 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. A patient who relapses following a conventional myeloablative allogeneic HSCT could undergo a second myeloablative procedure if a suitable donor is available and his or her medical status would permit it. However, this type of patient would likely undergo RIC prior to a second allogeneic HSCT if a complete remission could be re-induced with chemotherapy.

The ideal allogeneic donors are HLA-identical siblings, matched at the HLA-A, B, and DR loci (six of six). Related donors mismatched at one locus are also considered suitable donors. A matched, unrelated donor 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, with whom usually there is sharing of only three of the six 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.

Medicare Advantage

For Medicare Advantage autologous hematopoietic stem-cell transplantation (HSCT) is considered investigational to treat all chronic lymphocytic leukemia or small lymphocytic lymphoma.

Allogeneic HSCT may be medically necessary for chronic lymhoid leukemia or small lymphocytic leukemia in remission, having failed remission or in relapse.

Facilities performing stem cell transplants on Medicare Advantage members must be accredited by the Foundation for the Accreditation of Cellular Therapy and the Joint Accreditation Committee and compliant with the FACT-JACIE International Standards for Cellular Therapy Product Collection, Processing, and Administration manual.

Benefit Application

For all business individual transplant facilities may have their own additional requirements or protocols that must be met in order for the patient to be eligible for a transplant at their facility.

Services that are the subject of a clinical trial do not meet our Technology Assessment Protocol criteria and are considered investigational. For explanation of experimental and investigational, please refer to the Technology Assessment Protocol.

It is expected that only appropriate and medically necessary services will be rendered. We reserve the right to conduct prepayment and postpayment reviews to assess the medical appropriateness of the above-referenced procedures. Some of this Protocol may not pertain to the patients you provide care to, as it may relate to products that are not available in your geographic area.
References

We are not responsible for the continuing viability of web site addresses that may be listed in any references below.


27. CMS National Coverage Determination (NCD) for Stem Cell Transplantation (110.8.1), 11/10/10.

28. NGS Local Coverage Determination (LCD) for Stem Cell Transplantation (L30183), 11/01/11.