



MASSACHUSETTS

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Medical Policy

Hematopoietic Cell Transplantation for Hodgkin Lymphoma

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Policy Number: 207

BCBSA Reference Number: 8.01.29 (For Plan internal use only)

Related Policies

Hematopoietic Stem Cell Transplantation for Non-Hodgkin Lymphomas, #[143](#)

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Autologous hematopoietic cell transplantation (HCT) may be considered **MEDICALLY NECESSARY** in individuals with primary refractory or relapsed Hodgkin lymphoma.

Allogeneic HCT, using either myeloablative or reduced-intensity conditioning regimens, may be considered **MEDICALLY NECESSARY** in individuals with primary refractory or relapsed Hodgkin lymphoma.

Tandem autologous HCT is considered **INVESTIGATIONAL** in individuals with Hodgkin lymphoma.

Second autologous HCT for relapsed lymphoma after a prior autologous HCT is considered **INVESTIGATIONAL**.

Other uses of HCT in individuals with Hodgkin lymphoma are considered **INVESTIGATIONAL**, including, but not limited to, initial therapy for newly diagnosed disease to consolidate a first complete remission.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is required .
Commercial PPO and Indemnity	Prior authorization is required .

Requesting Prior Authorization Using Authorization Manager

Providers will need to use [Authorization Manager](#) to submit initial authorization requests for services. Authorization Manager, available 24/7, is the quickest way to review authorization requirements, request authorizations, submit clinical documentation, check existing case status, and view/print the decision letter. For commercial members, the requests must meet medical policy guidelines.

To ensure the service request is processed accurately and quickly:

- Enter the facility's NPI or provider ID for where services are being performed.
- Enter the appropriate surgeon's NPI or provider ID as the servicing provider, *not* the billing group.

Authorization Manager Resources

Refer to our [Authorization Manager](#) page for tips, guides, and video demonstrations.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

CPT codes:	Code Description
38241	Hematopoietic progenitor cell (HPC); autologous transplantation

HCPCS Codes

HCPCS codes:	Code Description
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 post-transplant care in the global definition (including drugs; hospitalization; medical surgical, diagnostic and emergency services)

ICD-10 Procedure Codes

ICD-10-PCS procedure codes:	Code Description
30233G0	Transfusion of Autologous Bone Marrow into Peripheral Vein, Percutaneous Approach

30233X0	Transfusion of Autologous Cord Blood Stem Cells into Peripheral Vein, Percutaneous Approach
30233Y0	Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Vein, Percutaneous Approach
30243G0	Transfusion of Autologous Bone Marrow into Central Vein, Percutaneous Approach
30243X0	Transfusion of Autologous Cord Blood Stem Cells into Central Vein, Percutaneous Approach
30243Y0	Transfusion of Autologous Hematopoietic Stem Cells into Central Vein, Percutaneous Approach
3E03305	Introduction of Other Antineoplastic into Peripheral Vein, Percutaneous Approach
3E04305	Introduction of Other Antineoplastic into Central Vein, Percutaneous Approach
3E05305	Introduction of Other Antineoplastic into Peripheral Artery, Percutaneous Approach
3E06305	Introduction of Other Antineoplastic into Central Artery, Percutaneous Approach

Description

Hodgkin Lymphoma

Hodgkin lymphoma (HL) is a relatively uncommon B-cell lymphoma. In 2023, the estimated number of new cases in the United States was approximately 8830, with 900 estimated deaths related to HL.¹ The disease has a bimodal distribution, with most patients diagnosed between the ages of 20 and 39 years, with a second peak in adults aged 65 years and older.

The 2008 World Health Organization classification divided HL into 2 main types²; these classifications did not change in the 2022 update³.

1. "Classical" HL
 - o Nodular sclerosis
 - o Mixed cellularity
 - o Lymphocyte depleted
 - o Lymphocyte-rich
2. Nodular lymphocyte-predominant HL.

In Western countries, "classical" HL accounts for 95% of cases of HL and, for nodular lymphocyte-predominant HL, only 5%.⁴ "Classical" HL is characterized by the presence of neoplastic Reed-Sternberg cells in a background of numerous non-neoplastic inflammatory cells. Nodular lymphocyte-predominant HL lacks Reed-Sternberg cells but is characterized by the presence of lymphocytic and histiocytic cells termed "popcorn cells".

Staging

The Ann Arbor staging system for HL recognizes that the disease is thought typically to arise in a single lymph node and spread to contiguous lymph nodes with eventual involvement of extranodal sites. The staging system attempts to distinguish patients with localized HL who can be treated with extended field radiation from those who require systemic chemotherapy.

Each stage is subdivided into A and B categories. "A" indicates no systemic symptoms are present and "B" indicates the presence of systemic symptoms, which include unexplained weight loss of more than 10% of body weight, unexplained fevers >38°C, or drenching night sweats (Table 1).⁴

Table 1. Ann Arbor Staging System for Hodgkin Lymphoma

Stage	Area of Concern
I	Single lymph node region (I) or localized involvement of a single extralymphatic organ or site (IE)
II	2 or more lymph node regions on the same side of the diaphragm (II) or localized involvement of a single associated extralymphatic organ or site and its regional lymph node(s) with or without involvement of other lymph node regions on the same side of the

	diaphragm (II _E). The number of lymph node regions involved should be indicated by a subscript (eg, II ₂).
III	Involvement of lymph node regions or structures on both sides of the diaphragm, which may involve an extralymphatic organ or site (III _E), spleen (III _S), or both (III _{E+S})
IV	Disseminated (multifocal) involvement of 1 or more extralymphatic organs, with or without associated lymph node involvement, or isolated extralymphatic organ involvement with distant (nonregional) nodal involvement

Patients with HL are generally classified into 3 groups: early-stage favorable (stage I-II with no B symptoms, large mediastinal lymphadenopathy, or other unfavorable factors), early-stage unfavorable (stage I-II with a large mediastinal mass, multiple involved nodal regions, B symptoms, extranodal involvement, or elevated erythrocyte sedimentation rate ≥ 50), and advanced-stage disease (stage III-IV).⁴

Treatment

Patients with nonbulky stage IA or IIA disease are considered to have the clinically early-stage disease. These patients are candidates for chemotherapy, combined modality therapy, or radiotherapy alone.⁵ Patients with obvious stage III or IV disease, bulky disease (defined as a 10-cm mass or mediastinal disease with a transverse diameter $>33\%$ of the transthoracic diameter), or the presence of B symptoms will require combination chemotherapy with or without additional radiotherapy.

Hodgkin lymphoma is highly responsive to conventional chemotherapy, and up to 80% of newly diagnosed patients can be cured with chemotherapy and/or radiotherapy. Patients who prove refractory or who relapse after first-line therapy have a significantly worse prognosis. Primary refractory HL is defined as disease regression of less than 50% after 4 to 6 cycles of anthracycline-containing chemotherapy, disease progression during induction therapy, or progression within 90 days after the completion of the first-line treatment.⁶

In patients with relapse, the results of salvage therapy vary depending on a number of prognostic factors, as follows: the length of the initial remission, stage at recurrence, and the severity of anemia at the time of relapse.⁷ Early and late relapse are defined as less or more than 12 months from the time of remission, respectively. Approximately 70% of patients with late first relapse can be salvaged by autologous hematopoietic cell transplantation (HCT) but not more than 40% with early first relapse.⁸

Only 25% to 35% of patients with primary progressive or poor-risk recurrent HL achieve durable remission after autologous HCT, with most failures being due to disease progression after transplant. Most relapses after transplant occur within 1 to 2 years, and once relapse occurs posttransplant, median survival is less than 12 months.

Hematopoietic Cell Transplantation

Hematopoietic cell transplantation is a procedure in which hematopoietic stem cells are intravenously infused to restore bone marrow and immune function in cancer patients who receive bone marrow-toxic doses of cytotoxic drugs with or without whole body radiotherapy. Hematopoietic stem cells may be obtained from the transplant recipient (autologous HCT) or a donor (allogeneic HCT [allo-HCT]). These cells can be harvested from bone marrow, peripheral blood, or umbilical cord blood shortly after delivery of neonates.

Immunologic compatibility between infused hematopoietic stem cells and the recipient is not an issue in autologous HCT. In allogeneic stem cell transplantation, immunologic compatibility between donor and patient is a critical factor for achieving a successful outcome. Compatibility is established by typing of human leukocyte antigens (HLA) using cellular, serologic, or molecular techniques. Human leukocyte antigen refers to the gene complex expressed at the HLA-A, -B, and -DR (antigen-D related) loci on each arm of chromosome 6. An acceptable donor will match the patient at all or most of the HLA loci.

Conditioning for Hematopoietic Cell Transplantation

Conventional Conditioning

The conventional (“classical”) practice of allo-HCT involves administration of cytotoxic agents (e.g., cyclophosphamide, busulfan) with or without total body irradiation at doses sufficient to cause bone marrow ablation in the recipient. The beneficial treatment effect of this procedure is due to a combination of the initial eradication of malignant cells and subsequent graft-versus-malignancy effect mediated by non-self-immunologic effector cells. While the slower graft-versus-malignancy effect is considered the potentially curative component, it may be overwhelmed by existing disease in the absence of pretransplant conditioning. Intense conditioning regimens are limited to patients who are sufficiently medically fit to tolerate substantial adverse effects. These include opportunistic infections secondary to loss of endogenous bone marrow function and organ damage or failure caused by the cytotoxic drugs. Subsequent to graft infusion in allo-HCT, immunosuppressant drugs are required to minimize graft rejection and graft-versus-host disease (GVHD), which increases susceptibility to opportunistic infections.

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

Reduced-Intensity Conditioning Allogeneic Hematopoietic Cell Transplantation

Reduced-intensity conditioning (RIC) refers to the pretransplant use of lower doses of cytotoxic drugs or less intense regimens of radiotherapy than are used in traditional full-dose myeloablative conditioning treatments. Although the definition of RIC is variable, with numerous versions employed, all regimens seek to balance the competing effects of relapse due to residual disease and non-relapse mortality. The goal of RIC is to reduce disease burden and to minimize associated treatment-related morbidity and non-relapse mortality in the period during which the beneficial graft-versus-malignancy effect of allogeneic transplantation develops. Reduced-intensity conditioning regimens range from nearly total 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. In this review, the term RIC will refer to all conditioning regimens intended to be nonmyeloablative.

Targeted Chemotherapy and Autologous Hematopoietic Cell Transplantation for the Treatment of Hodgkin Lymphoma

A recent important development in the HL treatment landscape is the emergence of several novel agents that are now being used as alternatives to stem cell transplantation in patients at high-risk for relapse after chemotherapy or relapse following autologous HCT. These agents include brentuximab vedotin, a CD30-directed antibody-drug conjugate, and nivolumab and pembrolizumab, which are 2 programmed death receptor-1 (PD-1) blocking antibodies. The U.S. Food and Drug Administration (FDA) regulatory status of these agents for the treatment of HL is summarized in Table 2.

Brentuximab vedotin was evaluated in a large, phase 3, multinational, double-blind randomized controlled trial (RCT) known as the AETHERA trial (abbreviation definition unknown). Moskowitz et al (2015)⁹ reported on the outcomes for 329 individuals with HL with risk factors for post-transplantation relapse or progression (eg, primary refractory HL, relapse <12 months after initial therapy, and/or relapse with extranodal disease). Results showed that early consolidation with brentuximab vedotin after autologous HCT significantly improved 2-year progression-free survival (PFS) versus placebo (63% vs. 51%, hazard ratio [HR] 0.57; 95% confidence interval [CI], 0.40 to 0.81). At 5-year follow-up, the significant PFS benefit for brentuximab vedotin persisted (59% vs. 41%; HR 0.52; 95% CI, 0.38 to 0.72).¹⁰ In addition, a study by Smith et al (2018)¹¹ of tandem autologous HCT observed that the 2-year PFS of 63% for brentuximab vedotin demonstrated in the AETHERA RCT “matches” the 2-year PFS rates for tandem autologous HCT.

A survival benefit with novel agents has been found in the setting of relapse post-autologous HCT. Bair et al (2017) reported a retrospective comparative analysis that evaluated the outcomes of 87 individuals with relapsed/refractory HL who had relapsed post-autologous HCT.¹² Compared to individuals who did not receive any novel agents, those that received novel agents, including brentuximab vedotin or nivolumab, experienced a significant improvement in median overall survival (85.6 vs. 17.1 months; $p < .001$). The availability of safe and effective targeted systemic therapy represents an alternative to the use of a second autologous transplant or planned tandem autologous HCT for HL consolidation treatment or relapse/refractory disease treatment.

Summary

Description

Hodgkin lymphoma (HL) results from a clonal expansion of a B-cell lineage, characterized by the presence of Reed-Sternberg cells on pathology. Standard treatment is based on the stage at presentation and may involve chemotherapy with or without radiotherapy. Hematopoietic cell transplantation (HCT) has been used for HL, particularly in the setting of relapse or refractory disease.

Summary of Evidence

Autologous Hematopoietic Cell Transplantation

For individuals who have Hodgkin lymphoma (HL) who receive autologous hematopoietic cell transplantation (HCT) as first-line therapy, the evidence includes randomized controlled trials (RCTs). Relevant outcomes are overall survival (OS), disease-specific survival (DSS), change in disease status, morbid events, and treatment-related mortality and morbidity. Randomized controlled trials of autologous HCT as first-line treatment have reported that this therapy does not provide additional benefit compared with conventional chemotherapy. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have relapsed or refractory HL who receive autologous HCT, the evidence includes RCTs, a meta-analysis, nonrandomized studies, and case series. Relevant outcomes are OS, DSS, change in disease status, morbid events, and treatment-related mortality and morbidity. Two RCTs in patients with relapsed or refractory disease have reported a benefit in PFS and a trend toward a benefit in OS. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have relapsed HL after an autologous HCT who receive a second autologous HCT, the evidence includes case series. Relevant outcomes are OS, DSS, change in disease status, morbid events, and treatment-related mortality and morbidity. No RCTs or nonrandomized comparative studies were identified. In a case series, treatment-related mortality at 100 days was 11%; at a median follow-up of 72 months, the mortality rate was 73%. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Allogeneic Hematopoietic Cell Transplantation

For individuals who have HL who receive allogeneic HCT (allo-HCT) as first-line therapy, the evidence includes no published studies. Relevant outcomes are OS, DSS, change in disease status, morbid events, and treatment-related mortality and morbidity. No studies specifically addressing allo-HCT as first-line treatment for HL were identified. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have relapsed or refractory HL who receive allo-HCT, the evidence includes a number of case series and a meta-analysis. Relevant outcomes are OS, DSS, change in disease status, morbid events, and treatment-related mortality and morbidity. A 2016 meta-analysis identified 38 case series evaluating allo-HCT for relapsed or refractory HL. The pooled analysis found a 6-month OS rate of 83% and a 3-year OS of 50%. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have relapsed HL after autologous HCT who receive allo-HCT, the evidence includes case series and a meta-analysis. Relevant outcomes are OS, DSS, change in disease status, morbid events, and treatment-related mortality and morbidity. A 2016 meta-analysis of 38 case series found that a previous autologous HCT followed by allo-HCT was significantly associated with higher 1- and 2-year OS rates and significantly higher recurrence-free survival rates at 1 year compared with no previous autologous HCT. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have relapsed or refractory HL who receive reduced-intensity conditioning (RIC) with allo-HCT, the evidence includes case series, cohort studies, and a systematic review. Relevant outcomes are OS, DSS, change in disease status, morbid events, and treatment-related mortality and morbidity. A 2015 systematic review cited a number of studies, including some with comparison groups, showing acceptable outcomes after RIC with allo-HCT in patients with relapsed or refractory HL. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Tandem Autologous Hematopoietic Cell Transplantation

For individuals who have HL who receive tandem autologous HCT, the evidence includes nonrandomized comparative studies and case series. Relevant outcomes are OS, DSS, change in disease status, morbid events, and treatment-related mortality and morbidity. One prospective, nonrandomized study reported that, in patients with poor prognostic markers, response to tandem autologous HCT might be higher than for single autologous HCT. This study was not definitive due to potential selection bias; RCTs are needed to determine the impact of tandem autologous HCT on health outcomes in this population. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Policy History

Date	Action
3/2024	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
9/2023	Policy clarified to include prior authorization requests using Authorization Manager.
3/2023	Annual policy review. Minor editorial refinements to policy statements; intent unchanged.
2/2022	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
3/2021	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2021	Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
11/2020	Annual policy review. Policy updated with clinical input. Policy statement on tandem autologous HCT in patients with Hodgkin lymphoma changed from medically necessary to investigational. Effective 11/1/2020.
4/2020	Bone marrow harvesting codes were removed. Outpatient prior authorization is not required.
3/2019	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2019	Outpatient prior authorization is required for all commercial products including Medicare Advantage. Effective 1/1/2019.
3/2018	Annual policy review. New references added.
2/2018	Coding information clarified.
6/2017	Annual policy review. Policy statement on reduced-intensity conditioning removed. Covered indications clarified. Title changed. New references added. Effective 6/1/2017.
9/2015	Clarified coding information.
6/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.

3/2014	Annual policy review. New references added.
12/2012	Updated to add new CPT code 38243.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
7/2011	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
9/2010	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
8/1/2010	New policy, effective 8/1/2010, describing covered and non-covered indications.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

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