Hematopoietic Cell Transplantation in the Treatment of Germ-Cell Tumors

Policy # 00056
Original Effective Date: 01/28/2002
Current Effective Date: 11/15/2017

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the “Company”), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage
Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- Benefits are available in the member’s contract/certificate, and
- Medical necessity criteria and guidelines are met.

Based on review of available data, the Company may consider the use of single autologous hematopoietic cell transplantation (HCT) as salvage therapy to treat patients with germ-cell tumors to be eligible for coverage when patient selection criteria are met.

Patient Selection Criteria
The use of single autologous hematopoietic cell transplantation (HCT) as salvage therapy for germ-cell tumors may be considered eligible for coverage when ANY of the following criteria are met:

- In patients with favorable prognostic factors that have failed a previous course of conventional-dose salvage chemotherapy; OR
- In patients with unfavorable prognostic factors as initial treatment of first relapse (i.e., without a course of conventional-dose salvage chemotherapy) and in patients with platinum-refractory disease.

Based on review of available data, the Company may consider tandem or sequential autologous hematopoietic cell transplantation (HCT) for the treatment of testicular tumors either as salvage therapy or with platinum-refractory disease to be eligible for coverage.

When Services Are Considered Investigational
Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers the use of single autologous hematopoietic cell transplantation (HCT) as salvage therapy to treat patients with germ-cell tumors when patient selection criteria are not met to be investigational.*

Based on review of available data, the Company considers autologous hematopoietic cell transplantation (HCT) as a component of first-line treatment for germ-cell tumors to be investigational.*
Based on review of available data, the Company considers allogeneic hematopoietic cell transplantation (HCT) to treat germ-cell tumors, including, but not limited to its use as therapy after a prior failed autologous hematopoietic cell transplantation (HCT) to be investigational.*

Note: The favorable and unfavorable prognostic factors are derived from the current National Comprehensive Cancer Network (NCCN) guidelines and the DeVita, Hellman, and Rosenberg’s textbook Cancer: Principles and Practice of Oncology.

Patients with favorable prognostic factors include those with a testis or retroperitoneal primary site, a complete response (CR) to initial chemotherapy, low levels of serum markers and low volume disease. Patients with unfavorable prognostic factors are those with an incomplete response to initial therapy or relapsing mediastinal nonseminomatus germ-cell tumors.

Background/Overview

GERM CELL TUMORS

Germ cell tumors are composed primarily of testicular neoplasms (seminomas or nonseminomatous tumors) as well as ovarian and extragonadal germ cell tumors (eg, retroperitoneal or mediastinal tumors). Germ cell tumors are classified according to their histology, stage, prognosis, and response to chemotherapy.

Germ cell tumor histologies include seminoma, embryonal carcinoma, teratoma, choriocarcinoma, yolk sac tumor, and mixed germ cell tumors. Seminomas are the most common; all other types are collectively referred to as nonseminomatous germ cell tumors.

Stage is dependent on location and extent of the tumor, using the American Joint Committee on Cancer’s TNM system. TNM stages, modified by serum concentrations of markers for tumor burden (S0-3) when available, are grouped by similar prognoses. Markers used for germ cell tumors include human β-chorionic gonadotropin (B-hCG), lactate dehydrogenase (LDH), and alpha fetoprotein (AFP). However, most patients with pure seminoma have normal AFP concentrations. For testicular tumors, stages IA to B tumors are limited to the testis (no involved nodes or distant metastases) and no marker elevations (S0); stages IIA to C have increasing size and number of tumor-involved lymph nodes, and at least 1 marker moderately elevated above the normal range (S1); and stages IIIA to C have distant metastases and/or marker elevations greater than specified thresholds (S2-3).

Germ cell tumors also are divided into good-, intermediate-, or poor-risk categories based on histology, site, and extent of primary tumor, and on serum marker levels. Good-risk pure seminomas can be at any primary site but are without nonpulmonary visceral metastases or marker elevations. Intermediate-risk pure seminomas have nonpulmonary visceral metastases with or without elevated hCG and/or LDH. There are no poor-risk pure seminomas, but mixed histology tumors and seminomas with elevated AFP (due to mixture with nonseminomatous components) are managed as nonseminomatous germ cell tumors. Good-
and intermediate-risk nonseminomatous germ cell tumors have testicular or retroperitoneal tumors without nonpulmonary visceral metastases, and either S1 (good risk) or S2 (intermediate) levels of marker elevations. Poor-risk tumors have mediastinal primary tumors, or nonpulmonary visceral metastases, or the highest level (S3) of marker elevations.

Therapy for germ cell tumors is generally dictated by stage, risk subgroup, and tumor histology. Testicular cancer is divided into seminomatous and nonseminomatous types for treatment planning because seminomas are more sensitive to radiotherapy. Stage I testicular seminomas may be treated by orchiectomy with or without radiation or single-dose carboplatin adjuvant therapy. Nonseminomatous stage I testicular tumors may be treated with orchiectomy with or without retroperitoneal lymph node dissection. Higher stage disease typically involves treatment that incorporates chemotherapy. First-line chemotherapy for good- and intermediate-risk patients with higher stage disease is usually 3 or 4 cycles of a regimen combining cisplatin and etoposide, with or without bleomycin depending on histology and risk group. Chemotherapy is often followed by surgery to remove residual masses. Second-line therapy often consists of combined therapy with ifosfamide/mesna and cisplatin, plus vinblastine, paclitaxel, or etoposide (if not used for first-line treatment). Patients whose tumors are resistant to cisplatin may receive carboplatin-containing regimens. The probability of long-term continuous complete remission diminishes with each successive relapse.

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 from a donor (allogeneic 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.

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 a critical factor for achieving a good outcome of allogeneic HCT. 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 class I and II loci on chromosome 6. Depending on the disease being treated, an acceptable donor will match the patient at all or most of the HLA loci (with the exception of umbilical cord blood).

FDA or Other Governmental Regulatory Approval
U.S. Food and Drug Administration (FDA)
The U.S. FDA regulates human cells and tissues intended for implantation, transplantation, or infusion through the Center for Biologics Evaluation and Research, under Code of Federal Regulation (CFR) title 21, parts 1270 and 1271. Hematopoietic stem cells are included in these regulations.
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Centers for Medicare and Medicaid Services (CMS)
There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

Rationale/Source
AUTOLOGOUS HEMATOPOIETIC CELL TRANSPLANTATION AS FIRST-LINE THERAPY OF GERM CELL TUMORS
Daugaard et al (2011) reported the outcomes of a randomized phase 3 study comparing standard-dose cisplatin, etoposide, and bleomycin (BEP) to sequential high-dose cisplatin, etoposide, and ifosfamide (VIP) plus stem cell support in previously untreated males with poor-prognosis germ cell cancer. The trial aimed to recruit 222 patients but closed with 137 patients from 27 European oncology centers due to slow accrual. Patients were ages 15 to 50 years and had previously untreated metastatic poor-prognosis nonseminomatous germ cell tumor of testicular or extragonadal origin. Median follow-up was 4.4 years. Toxicity was more severe in patients who received high-dose chemotherapy (HDC), and toxic death was reported in 2 patients who received HDC and in 1 patient in the BEP arm. There was no improvement in complete response (CR) rate in the HDC arm (44.6%) versus the standard-dose arm (33.3%; p=0.18). There was no difference in failure-free survival (FFS) between the 2 groups. At 2 years, FFS rates were 44.8% (95% confidence interval [CI], 32.5% to 56.4%) and 58.2% (95% CI, 48.0% to 71.9%), respectively, for the standard- and high-dose arms. The difference was not statistically significant (p=0.06). Overall survival (OS) did not differ between groups (p>0.1). The authors concluded that HDC given as part of first-line therapy does not improve outcomes in patients with poor-prognosis germ cell tumor.

Motzer et al (2007) reported on a phase 3 prospective, randomized, multicenter trial of 219 previously untreated patients with poor-prognosis germ cell tumors. Median patient age was 28 years. Patients were randomized to receive conventional chemotherapy (4 cycles of BEP; n=111), or 2 cycles of BEP followed by 2 cycles of HDC with autologous HCT. Median follow-up was 51 months. One-year durable CR rate was 52% after BEP plus HDC with HCT, and 48% after BEP alone (p=0.53). There was no survival difference at 106 months for patients treated with HDC and HCT (68%) compared with patients treated with conventional chemotherapy (69%).

Droz et al (2007) assessed the impact of HDC plus HCT on the survival of patients with high-volume, previously untreated, metastatic nonseminomatous germ cell tumors. Patients were randomized to 4 cycles every 21 days of vinblastine, etoposide, cisplatin, and bleomycin (n=57) or a slightly modified regimen followed by HDC and autologous HCT (n=57). In an intention-to-treat (ITT) analysis, the CR rates were 56% and 42% for the conventional and HDC groups, respectively (p=0.099). Median follow-up was 9.7 years, and no significant difference in OS between groups (p=0.167).

Section Summary: Autologous Hematopoietic Cell Transplantation as First-Line Therapy for Germ Cell Tumors
The evidence from several randomized trials found that autologous HCT as initial therapy for germ cell tumors did not significantly improve outcomes compared with alternative therapy (eg, standard-dose
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However, study sample sizes were relatively small and may have been underpowered to detect differences between groups.

**AUTOLOGOUS HCT FOR RELAPSED OR REFRACTORY GERM CELL TUMORS**

One randomized controlled trial (RCT) was identified. In 2005, Pico et al reported on a randomized trial comparing 4 cycles of conventional-dose chemotherapy with 3 cycles of the same regimen followed by carboplatin-based HDC plus autologous HCT in 280 patients who had relapsed after a complete or partial remission following first-line therapy with a cisplatin-based regimen. The authors reported no significant differences between treatment arms in 3-year event-free survival (EFS) or OS. However, the trial began before international consensus established the current risk group definitions; thus, Pico et al likely included patients now considered to have good prognosis at relapse. Furthermore, while 77% and 86% of patients in the control and experimental arms, respectively, had at least 1 elevated serum tumor marker, they did not report how highly elevated rates were or compare arms with respect to the marker thresholds that presently determine risk level (S1-3). Finally, HDC in the experimental arm followed 3 cycles of conventional-dose chemotherapy, which differs from most current practice in the United States, in which a single cycle is used before HDC. As a consequence, 38 (28%) of 135 patients randomized to the HDC arm did not receive HDC because of progression, toxicity, or withdrawal of consent.

In addition, there are several case series. Seftel et al (2011) conducted a multicenter study of consecutive patients undergoing a single autologous HCT for germ cell tumor between January 1986 and December 2004. For 71 subjects, median follow-up was 10.1 years. Median age was 31 years (range, 16-58 years). Sixty-seven patients had nonseminomatous germ cell tumors and 4 had seminomatous germ cell tumors. Fifty-seven patients had primary gonadal disease and 14 had primary extragonadal disease. Of the latter, 11 patients presented with primary mediastinal disease, 2 presented with primary central nervous system (CNS) disease, and 1 presented with retroperitoneal disease. In all, 28 patients underwent autologous HCT for relapsed disease after achieving an initial CR. Of these, 24 patients underwent autologous HCT after a first relapse and 4 patients underwent transplant after a second relapse. An additional 36 patients achieved only an incomplete response after initial therapy and proceeded to autologous HCT for salvage chemotherapy for active residual disease. OS at 5 years was 44.7% (95% CI, 32% to 56.5%) and EFS was 43.5% (95% CI, 31.4% to 55.1%). There were 7 (10%) treatment-related deaths within 100 days of transplant. Three (4.2%) patients developed secondary malignancies. Of 33 relapses, 31 occurred within 2 years of the transplant. Two very late relapses occurred 13 and 11 years after transplant. In a multivariate analysis, a favorable outcome was associated with International Germ Cell Consensus Classification (IGCCC) good prognosis disease at diagnosis, primary gonadal disease, and response to salvage chemotherapy.

Agarwal et al (2009) reported their experience at a single center in treating 37 consecutive patients who received HDC and autologous HCT between 1995 and 2005 for relapsed germ cell tumors. Median patient age was 28 years (range, 9-59 years), with 34 males and 3 females. Primary tumor sites included 24 testes/adnexal, 10 chest/neck/retroperitoneal, and 3 CNS. Twenty-nine of the patients had received prior...
standard salvage chemotherapy. Three-year OS was 57% (95% CI, 41% to 71%), and 3-year progression-free survival (PFS) was 49% (95% CI, 33% to 64%).

Baek et al (2013) reported results of a small feasibility study of HDC followed by HCT for patients with relapsed or progressed CNS germ cell tumors. Investigators enrolled 11 patients with nongerminomatous (ie, nonseminomatous) germ cell tumors and 9 patients with germinomatous stem cell tumors, all of whom had received conventional chemotherapy with or without radiation before HCT. Sixteen patients received an initial course of HDC with carboplatin, thiopental, and etoposide followed by HCT, and 9 of those received a second course of HDC with cyclophosphamide-melphalan followed by a second HCT (see the Tandem and Sequential HCT for Germ Cell Tumors section next). Twelve patients remained alive at a median follow-up of 47 months (range, 22-90 months), with a probability of 3-year OS of 59.1%.

In 2015, Nieto et al reported on 43 male patients with poor-risk relapsed or refractory germ cell tumors with received HDC and autologous HCT. Primary tumors were testicular in 32 patients, mediastinal in 7 patients, and retroperitoneal in 4 patients. Median follow-up was 46 months (range, 9-84 months). At follow-up, the relapse-free survival rate was 55.8% and the OS rate was 58.1%. Relapse-free survival rates were 66% in patients with testicular primaries, 28.5% in patients with mediastinal primaries and 25% in patients with retroperitoneal primaries.

Section Summary: Autologous HCT for Relapsed or Refractory Germ Cell Tumors
The single published RCT did not find improved outcomes with HDC and autologous HCT than with standard-dose HCT. Case series had sample sizes ranging between 11 and 71 patients each. Three-year OS rates in the case series ranged between 55% and 60%.

TANDEM AND SEQUENTIAL HCT FOR GERM CELL TUMORS
There is ongoing research into the role of tandem and sequential HCT for germ cell tumors, with a variety of specific chemotherapy regimens.

Lorch et al (2007) compared single- to sequential HDC with autologous HCT as first or subsequent salvage treatment in patients with relapsed or refractory germ cell tumors. Patients were randomized to 2 different HDC regimens (arm A, arm B). Most tumors were gonadal primaries; 10% of patients in arm A had retroperitoneal, mediastinal, or CNS primaries, and 11% of patients in arm B had retroperitoneal or mediastinal primaries. This represented the first salvage therapy received for 86% of the patients in arm A and 85% in arm B, whereas 14% in arm A and 15% in arm B had received 1 or more previous salvage regimens before randomization. A total of 111 (51%) of 216 patients were randomized to sequential high-dose therapy, and 105 (47%) of 216 patients were randomized to single high-dose therapy. The trial was stopped prematurely after recruitment of 216 patients as a result of excess treatment-related mortality in arm B (sequential). There was a planned interim analysis after the inclusion of 50% of the required total number of patients. Survival analyses were performed on an ITT basis.
At a median follow-up of 36 months, 109 (52%) of 211 patients were alive, and 91 (43%) of 211 patients were progression-free. At 1 year, EFS, PFS, and OS rates were 40%, 53%, and 80%, respectively, in arm A compared with 37%, 49%, and 61%, respectively, in arm B (p>0.05 for all comparisons). Survival rates were not reported separately by primary site of the tumor. No difference in survival probabilities was found between the single and sequential high-dose regimens; however, sequential high-dose therapy was better tolerated and resulted in fewer treatment-related deaths. Treatment-related deaths, mainly as a result of sepsis and cardiac toxicity, were less frequent in arm A (4/108 [4%] patients) than in arm B (16/103 [16%] patients; p<0.01). The authors attributed the higher rate of treatment-related deaths in arm B to the higher dosages per HCT cycle in the arm B regimen compared with arm A, as well as the toxic renal and cardiac effects of cyclophosphamide used in arm B.

Lorch et al (2012) reported long-term results from this study; 5-year PFS rates were 47% (95% CI, 37% to 56%) in arm A and 45% (95% CI, 35% to 55%) in arm B (hazard ratio [HR], 1.16; 95% CI, 0.79 to 1.70; p=0.454). Five-year OS rates were 49% (95% CI, 40% to 59%) in arm A and 39% (95% CI, 30% to 49%) in arm B (HR=1.42; 95% CI, 0.99 to 2.05; p=0.057). The authors concluded that patients with relapsed or refractory germ cell tumors could achieve durable long-term survival after single as well as sequential HCT and that fewer early deaths related to toxicity translated into superior long-term OS after sequential HCT.

Lazarus et al (2007) reported on the results of autologous HCT in relapsed testicular/germ cell cancer from registry data at the Center for International Blood and Marrow Transplant Research. Patients with mediastinal primaries were excluded. Data included 300 patients from 76 transplant centers in 8 countries who received either a single or tandem autologous HCT between 1989 and 2001. Of the 300 patients, 102 received tandem and 198 received single planned autologous HCT. PFS and OS rates at 1, 3, and 5 years were similar for both groups. The probability of PFS at 5 years for the tandem transplant group was 34% (95% CI, 25% to 44%) versus 38% (95% CI, 31% to 45%) for the single transplant group (p=0.50). The probability of 5-year OS was 35% (95% CI, 25% to 46%) versus 42% (95% CI, 35% to 49%), respectively (p=0.29).

Lotz et al (2005) reported on the results of a phase 2 study on 3 consecutive cycles of HDC regimens supported by autologous HCT in 45 poor-prognosis patients with relapsed germ cell tumors. From March 1998 to September 2001 (median follow-up, 31.8 months), 45 patients (median age, 28 years) were enrolled. Most patients (76%) had testicular primaries; 13% had mediastinal primaries; 11% had retroperitoneal, hepatic, or unknown. Of all patients, 22 received the complete course. Twenty-five patients died from progression and 5 from toxicity. The overall response rate was 37.7%, including an 8.9% CR rate. Median OS was 11.8 months. The 3-year OS and PFS rate was 23.5%. Authors used the Beyer prognostic score to predict the outcome of HDC and concluded that patients with a Beyer score greater than 2 did not benefit from this approach, confirming that highly refractory patients and particularly patients with resistant or refractory primary mediastinal germ cell tumors do not benefit from HDC.

Einhorn et al (2007) reported retrospectively on a series of 184 patients, treated between 1996 and 2004, with 2 consecutive cycles of HDC for metastatic testicular cancer that had progressed (relapsed) after
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receiving cisplatin-containing combination chemotherapy. Patients with primary mediastinal nonseminomatous germ cell tumors or tumors with late relapse (≥2 years after previous therapy) were excluded. The patient population included those with initial IGCCC stage defined as low risk (39%), intermediate risk (21%), and high risk (41%) and both platinum-sensitive and refractory disease at the beginning of HDC. Results from this experienced center showed that, of the 184 patients, 116 had complete remission of disease without relapse during a median follow-up of 48 months. Of the 135 patients who received the treatment as second-line therapy (ie, first salvage setting), 94 (70%) were disease-free during follow-up; 22 (45%) of 49 patients who received treatment as third-line or later therapy were disease-free. Of 40 patients with cancer refractory to standard-dose platinum, 18 (45%) were disease-free.

Caveats on the Einhorn et al study include the lack of a validation set for the prognostic scoring system used; the unanswered question of the role of high-dose versus conventional-dose chemotherapy in the first salvage setting; and the lack of a universally accepted prognostic scoring system in this setting.

In a subsequent study from the same center as the Einhorn et al study, Suleiman et al (2013) evaluated outcomes for 12 patients with recurrent primary mediastinal nonseminomatous germ cell tumors after initial treatment with cisplatin-containing combination chemotherapy, a population excluded from their previous study, who were treated with tandem HCT. Patients received 2 consecutive courses of HDC (carboplatin and etoposide) followed by HCT. Overall outcomes were poor, with a median survival of 11 months (range, 4-52 months), but 3 of 12 patients achieved a CR. One patient remained disease-free at 50 months of follow-up, and 1 remained disease-free after tandem HCT and subsequent mediastinal surgery at 52 months of follow-up.

Pal et al (2013) reported on 5-year follow-up results from 48 patients with relapsed germ cell tumors enrolled in a retrospective case series to evaluate the effectiveness of 2 sequential cycles of chemotherapy with paclitaxel, etoposide, and carboplatin in the first cycle, high-dose paclitaxel, ifosfamide, and carboplatin in the second and then by HCT. Forty-three (91.5%) patients had nonseminomatous histology. Most patients (n=39) had received 2 prior chemotherapy regimens; 6 patients had received 3 prior regimens. Thirty-four patients had intermediate-risk classification by the Beyer score and the remainder had high-risk classification. Of the 48 patients enrolled, 17 received only 1 course of paclitaxel, etoposide, and carboplatin, 11 due to progressive disease, 5 due to toxicities, and 1 due to a severe fungal infection. Seventeen of the 48 patients enrolled were alive and progression-free at a median of 123.2 months (range, 51.6-170.2 months); 25 died, most (n=23) due to disease progression. Of the 23 patients alive after receiving per-protocol therapy, 18 were contacted for interviews at a median 115.6 months (range, 38.9-185.9 months) postenrollment and underwent a cancer-related quality-of-life assessment with the European Organization for the Research and Treatment of Cancer Quality of Life Questionnaire–Core 30. The overall average score on the questionnaire was 87.04; the authors compared quality-of-life scores in this cohort to a separate cohort of 150 patients with germ cell tumors who received chemotherapy, and reported that patients in their cohort had significantly higher global health scores (87.04 vs 75.62, p=0.02), but lower physical functioning scores (68.9 vs 92.7, p<0.001). The authors concluded that tandem HDC followed by
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HCT would be a reasonable treatment option for relapsed germ cell tumors, with long-term survivors demonstrating a reasonable quality of life.

A 2012 comparative effectiveness review, conducted for the Agency for Healthcare Research and Quality, on the use of HCT in the pediatric population concluded that, for germ cell tumors, the body of evidence on OS with tandem HCT compared with single HCT was insufficient to draw conclusions.

Section Summary: Tandem and Sequential HCT for Germ Cell Tumors
One RCT compared tandem and sequential HCT for germ cell tumors. This RCT showed higher treatment-related mortality with sequential HCT than with single HCT. Five-year survival outcomes, however, did not show significant differences between groups. Observational studies have included heterogeneous patient populations, in different salvage treatment settings (ie, first vs subsequent salvage therapy), and lacked a universally accepted prognostic scoring system to risk-stratify patients.

ALLOGENEIC HCT FOR GERM CELL TUMORS
No RCTs or non-RCTs evaluating allogeneic HCT for germ cell tumors were identified. One 2007 case report described successful treatment of a refractory mediastinal gem cell tumor with allogeneic HCT.

Section Summary: Allogeneic HCT for Germ Cell Tumors
There is a lack of comparative studies evaluating allogeneic HCT for germ cell tumors. Only a case report was identified.

SUMMARY OF EVIDENCE
For individuals who have previously untreated germ cell tumors who receive first-line treatment with autologous HCT, the evidence includes randomized controlled trials (RCTs). Relevant outcomes are overall survival, disease-specific survival, and treatment-related mortality and morbidity. The available trials found after autologous HCT as initial therapy for germ cell tumors did not significantly improve outcomes compared with alternative therapy (eg, standard-dose chemotherapy). Study sample sizes were relatively small and may have been underpowered to detect differences between groups. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have relapsed or refractory germ cell tumors who receive autologous HCT, the evidence includes 1 RCT and several case series. Relevant outcomes are overall survival, disease-specific survival, and treatment-related mortality and morbidity. The RCT did not find significant differences in outcomes between autologous HCT plus high-dose chemotherapy and standard-dose chemotherapy. Case series found 3-year overall survival rates that ranged from 55% to 60%; these studies lacked comparison groups. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who germ cell tumors who receive tandem or sequential HCT, the evidence includes 1 RCT, several retrospective cohort studies, and a comparative effectiveness review. Relevant outcomes are overall survival, disease-specific survival, and treatment-related mortality and morbidity. The RCT found a
higher rate of treatment-related mortality with sequential HCT than with single HCT. However, 5-year survival outcomes did not differ significantly between groups. Overall, the available studies have included heterogeneous patient populations, in different salvage treatment settings (ie, first vs subsequent salvage therapy), and have lacked a universally accepted prognostic scoring system to risk-stratify patients. Tandem or sequential HCT has not shown benefit in patients with primary mediastinal germ cell tumors. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have germ cell tumors who receive allogeneic HCT, the evidence includes a case report. Relevant outcomes are overall survival, disease-specific survival, and treatment-related mortality and morbidity. There were no RCTs or non-RCTs evaluating allogeneic HCT for germ cell tumors. One 2007 case report described successful treatment of a refractory mediastinal gem cell tumor with allogeneic HCT. The evidence is insufficient to determine the effects of the technology on health outcomes.

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Policy History

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12/06/2001 Medical Policy Committee review
01/28/2002 Managed Care Advisory Council approval
06/24/2002 Format revision. Policy addresses only Germ Cell Tumors. Replaces high dose chemotherapy with hematopoietic stem cell support.
03/31/2004 Medical Director review
04/20/2004 Medical Policy Committee review. Format revision. No substance change to policy.
04/26/2004 Managed Care Advisory Council approval
05/03/2005 Medical Director review
05/17/2005 Medical Policy Committee review. Format revision. Policy statement corrected to reflect “that HDC and autologous SCS as initial treatment (i.e., in lieu of an initial course of conventional chemotherapy) of poor-risk germ cell tumors or as initial treatment of a first relapse (i.e., in lieu of a course of conventional chemotherapy) is investigational”.
05/23/2005 Managed Care Advisory Council approval
05/03/2006 Medical Director review
05/17/2006 Medical Policy Committee approval. Format revision, including addition of FDA and or other governmental regulatory approval and rationale_Source. Coverage eligibility unchanged.
10/10/2007 Medical Director review
10/17/2007 Medical Policy Committee approval. No change to coverage eligibility.
10/10/2008 Medical Director review
10/22/2008 Medical Policy Committee approval. No change to coverage eligibility.
10/01/2009 Medical Policy Committee approval

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10/14/2009 Medical Policy Implementation Committee approval. Title changed from “High-Dose Chemotherapy with Stem Cell Support for Germ Cell Tumors” to “Hematopoietic Stem Cell Transplantation in the Treatment of Germ Cell Tumors”. No change to coverage eligibility.

10/14/2010 Medical Policy Committee review

10/20/2010 Medical Policy Implementation Committee approval. Terminology changed in coverage statements. Coverage statements changed to indicate that tandem-sequential autologous stem-cell transplantation may be considered eligible for coverage in certain types of testicular cancers.

10/06/2011 Medical Policy Committee review

10/19/2011 Medical Policy Implementation Committee approval. “Based on review of available data, except as noted above for treatment of certain testicular tumors, the Company considers tandem or sequential autologous hematopoietic stem-cell transplantation to treat germ-cell tumors of any stage to be investigational” was deleted from coverage.

10/11/2012 Medical Policy Committee review

10/31/2012 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

03/04/2013 Coding update

10/03/2013 Medical Policy Committee review

10/16/2013 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

11/06/2014 Medical Policy Committee review


08/03/2015 Coding update: ICD10 Diagnosis code section added; ICD9 Procedure code section removed.

10/29/2015 Medical Policy Committee review

11/16/2015 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

11/03/2016 Medical Policy Committee review


01/01/2017 Coding update: Removing ICD-10 Diagnosis Codes

11/02/2017 Medical Policy Committee review


Next Scheduled Review Date: 11/2018

Coding
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<td>38204, 38205, 38206, 38207, 38208, 38209, 38210, 38211, 38212, 38213, 38214, 38215, 38230, 38232, 38240, 38241, 38242, 38243</td>
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<tr>
<td>HCPCS</td>
<td>S2140, S2142, S2150</td>
</tr>
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<td>ICD-10 Diagnosis</td>
<td>C38.1-C38.8, C48.0, C56.1-C56.9, C62.00-C62.02, C62.10-C62.12, C62.90-C62.91</td>
</tr>
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</table>

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or

B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:

1. Consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other nonaffiliated technology evaluation center(s);
2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
3. Reference to federal regulations.*

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;

B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and

C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.**

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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