Hematopoietic Stem-Cell Transplantation for Multiple Myeloma

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Place(s) of Service: Outpatient; Inpatient

Precertification is required for this service.

I. 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 and placenta 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 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 Class I and Class II 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 (with the exception of umbilical cord blood).

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 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 to be the potentially curative component, it may be overwhelmed by extant disease without the use of pretransplant conditioning. However, intense conditioning regimens are limited to patients who are sufficiently fit medically to tolerate substantial adverse effects that include pre-engraftment opportunistic infections secondary to loss of endogenous bone marrow function and organ damage and failure caused by the cytotoxic drugs. Furthermore, in any allogeneic HSCT, immunosuppressant 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 traditional full-dose myeloablative conditioning treatments. The goal of RIC is to reduce disease burden but also to minimize as much as possible associated treatment-related morbidity and non-relapse mortality (NRM) in the period during which the beneficial GVM effect of allogeneic transplantation develops. Although the definition of RIC remains arbitrary, with numerous versions employed, all seek to balance the competing effects of NRM and relapse due to residual disease. RIC regimens can be viewed as a continuum in effects, from nearly totally myeloablative to minimally myeloablative with lymphoablation, with intensity tailored to specific diseases and patient condition. Patients who undergo RIC with allogeneic HSCT initially demonstrate donor cell engraftment and bone marrow mixed chimerism. Most will subsequently convert to full-donor chimerism, which may be supplemented with donor lymphocyte infusions to eradicate residual malignant cells.

For the purposes of this Policy, the term “reduced-intensity conditioning” will refer to all conditioning regimens intended to be non-myeloablative, as opposed to fully myeloablative (traditional) regimens.

Multiple Myeloma

Multiple myeloma is a systemic malignancy of plasma cells that represents approximately 10% of all hematologic cancers. It is treatable but rarely curable, with estimated new cases and deaths in 2008 in
Hematopoietic Stem Cell Transplantation for Multiple Myeloma

The United States 19,920 and 10,690, respectively. (1) At the time of diagnosis most patients have generalized disease, and, the selection of treatment is influenced by patient age, general health, prior therapy, and the presence of complications of the disease. (1)

The disease is staged by estimating tumor mass, based on various clinical parameters like hemoglobin, serum calcium, number of lytic bone lesions, and the presence or absence of renal failure. (1) Multiple myeloma usually evolves from an asymptomatic premalignant stage (termed “monoclonal gammopathy of undetermined significance” or MGUS). Treatment is usually reserved for patients with symptomatic disease (usually progressive myeloma), whereas asymptomatic patients are observed, as there is little evidence that early treatment of asymptomatic multiple myeloma prolongs survival when compared to therapy delivered at the time of symptoms or end-organ damage. (1,2) In some patients, an intermediate asymptomatic but more advanced premalignant stage is recognized, and referred to as smoldering multiple myeloma. (3) The overall risk of disease progression from smoldering to symptomatic multiple myeloma is 10% per year for the first 5 years, approximately 3% per year for the next 5 years, and 1% for the next 10 years. (2)

II. Policy

A single or second (salvage) autologous hematopoietic stem-cell transplantation is covered to treat multiple myeloma.

Tandem autologous-autologous hematopoietic stem-cell transplantation is covered to treat multiple myeloma in patients who fail to achieve at least a near-complete* or very good partial response* after the first transplant in the tandem sequence. (For definitions of near-complete response and very good partial response, see Policy Guidelines).

Tandem transplantation with an initial round of autologous hematopoietic stem-cell transplantation followed by a non-marrow-ablative conditioning regimen and allogeneic hematopoietic stem-cell transplantation (i.e., reduced-intensity conditioning transplant) is covered to treat newly diagnosed multiple myeloma patients.

Allogeneic hematopoietic stem-cell transplantation, myeloablative or nonmyeloablative, is not covered as upfront therapy of newly diagnosed multiple myeloma or as salvage therapy.

*A near complete response, as defined by the European Group for Blood and Marrow Transplant (EBMT) is the disappearance of M protein at routine electrophoresis, but positive immunofixation. (4) A very good partial response has been defined as a 90% decrease in the serum paraprotein level. (5)

III. Administrative Guidelines

Precertification is required. To precertify, please complete HMSA's Precertification Request and mail or fax the form as indicated along with the required documentation.
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<td>Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications including pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre- and posttransplant care in the global definition</td>
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IV. Rationale

Overview of the treatment of multiple myeloma

In the prechemotherapy era, the median survival for a patient diagnosed with multiple myeloma was approximately 7 months. After the introduction of chemotherapy (e.g., the alkylating agent melphalan in the 1960s) prognosis improved with a median survival of 24–30 months and a 10-year survival of 3%.

(1) In a large group of patients with newly diagnosed multiple myeloma, there was no difference in overall survival (OS) reported during a 24-year period from 1971–1994, with a trend toward improvement during 1995–2000 and a statistically significant benefit in OS during 2001–2006. (2) These data suggested that autologous SCT was responsible for the trends during 1994–2000, while novel agents have contributed to the improvement since 2001. (2)

The introduction of novel agents and better prognostic indicators have been the major advances in the treatment of this disease. (10) Novel agents such as the proteasome inhibitor bortezomib and the immunomodulatory derivatives thalidomide and lenalidomide first showed efficacy in relapsed/refractory myeloma and now have been integrated into first-line regimens. (10) With the introduction of these novel treatments, it is now expected that most patients with multiple myeloma will have responsive disease with initial therapy, and only a small minority will have refractory disease. (11)

Risk-adapted therapy

The approach to the treatment of newly diagnosed MM (symptomatic) is dictated by eligibility for autologous HSCT and risk-stratification. (12) Risk stratification, using fluorescent in situ hybridization and conventional karyotyping divides patients into standard or high-risk categories.

High-risk patients, which comprise approximately 25% of patients with MM, are defined by any of the following cytogenetic findings: 17p deletion, t(4;14), t(14;16), t(14;20), deletion 13 or hypodiploidy. (12) Standard-risk patients are those with hyperdiploidy, t(11;14) or t(6;14).

Standard-risk patients are typically treated with non-alkylator-based therapy such as lenalidomide plus low-dose dexamethasone followed by autologous HSCT, however, if the patient is tolerating the induction regimen well, an alternative strategy is to continue the initial therapy after hematopoietic stem cell collection, reserving the transplant for first relapse. High-risk patients are generally treated with a bortezomib-based induction followed by autologous HSCT and then bortezomib-based maintenance. (12)

Single Autologous HSCT versus standard chemotherapy

As a result of several prospective, randomized trials that were conducted comparing conventional chemotherapy with high-dose therapy and autologous HSCT for patients with multiple myeloma, autologous HSCT has become the treatment of choice in patients younger than 65 years of age.
Data from 7 randomized studies are available. (13-19) In all but 1 study, (18) the complete response (CR) rate was superior in the high-dose chemotherapy/autologous HSCT arm: this study published final results of the S9321 trial, which was initiated in 1993 and randomized 516 patients with MM to receive either standard therapy or myeloablative conditioning with melphalan 140 mg/m2 plus total body irradiation followed by autologous HSCT. (18) The authors reported virtually no difference in outcomes, including response rates, progression-free survival (PFS), and OS.

In 5 of the 7 studies, the superior CR rate translated into a significant increase in PFS. However, in the 2 studies that did not show an improved PFS with autologous HSCT, randomization was not performed at diagnosis but only after induction treatment, possibly introducing selection bias. (19) Three of the 7 studies showed superior OS in the autologous HSCT group.(13,14,16)

The Intergroupe Francophone du Myélome (IFM) showed the superiority of high-dose chemotherapy and autologous HSCT compared to conventional chemotherapy in a randomized trial of 200 patients younger than 65 years of age. (13) The group that underwent autologous HSCT had significantly improved response rates, event-free (EFS) and overall survival. Seven years later, the British Medical Research Council published similar results. (14)

The reasons for the discrepant results among these randomized studies are uncertain, but may be related to the conditioning regimens or patient age.

A meta-analysis of 2,411 patients enrolled in randomized controlled trials (RCTs) compared standard dose chemotherapy versus myeloablative chemotherapy with single autologous HSCT. (20) The authors of the meta-analysis concluded that myeloablative therapy with autologous HSCT increased the likelihood of PFS (hazard of progression: 0.75; 95% confidence interval [CI]: 0.59–0.96) but not OS (hazard of death: 0.92; 95% CI: 0.74–1.13); the odds ratio for treatment-related mortality (TRM) was 3.01 (95% CI: 1.64–5.50) in the group with autologous HSCT. However, the effects of myeloablative chemotherapy and autologous HSCT may have been diluted by the fact that up to 55% of patients in the standard chemotherapy group received myeloablative chemotherapy with autologous HSCT as salvage therapy when the multiple myeloma progressed. This could account for the lack of a significant difference in OS between the two groups in the study.

These randomized trials of autologous HSCT following induction therapy were designed and implemented prior to the availability of thalidomide, lenalidomide, and bortezomib. The introduction of these agents has dramatically changed the treatment paradigm of MM. Ongoing trials incorporating these newer agents into induction regimens are ongoing. Preliminary results have shown CRs in a substantial proportion of these patients, opening the question as to what role autologous HSCT will continue to play. However, it will require further follow-up to determine if these newer induction regimens will translate into improved survival. (21)

Salvage transplantation

Despite the success in improved survival with autologous HSCT versus conventional chemotherapy, nearly all patients will relapse and require salvage therapy. Therapeutic options for patients with
relapsed MM after a prior autologous HSCT include novel biologic agents (e.g., thalidomide, lenalidomide, and bortezomib, as single agents, in combination with dexamethasone, and in combination with cytotoxic agents or with each other), traditional chemotherapy, or a second HSCT. (22)

**Repeat Autotransplant for Relapse After Initial Autotransplant**

An evidence-based systematic review (23) sponsored by the American Society for Blood and Marrow Transplantation (ASBMT) summarized data from 4 relevant clinical series. Investigators reported that some myeloma patients who relapsed after a first autotransplant achieved durable complete or partial remissions after a second autotransplant as salvage therapy. Factors that apparently increased the likelihood of durable remissions and extended survival included a chemosensitive relapse, younger age, a long disease-free or progression-free interval since the initial autotransplant, and fewer chemotherapy regimens prior to the initial autotransplant. Thus, clinical judgment plays an important role in selecting patients for this treatment with a reasonable likelihood that potential benefits may exceed harms.

Olin and colleagues reported their experience with 41 patients with MM who received a second salvage autologous HSCT for relapsed disease. (22) Median time between transplants was 37 months (range 3–91 months). Overall response rate in assessable patients was 55%. Treatment-related mortality was 7%. Median follow-up time was 15 months, with median PFS of 8.5 months and median OS 20.7 months. In a multivariate analysis of OS, the number of prior lines of therapy (≥5) and time to progression after initial transplant were the strongest predictors of OS.

**Allogeneic transplant for Relapse After Initial Autotransplant**

Qazilbash and colleagues reported their experience with salvage autologous or allogeneic transplantation after a failed first autologous transplant. (24) Fourteen patients (median age: 52 years) received a second autologous transplant and 26 patients (median age: 51 years) underwent a reduced-intensity allogeneic transplant. Median interval between first and second transplant was 25 and 17 months for the autologous and allogeneic groups, respectively. After a median follow-up of 18 months (range: 2–69 months) for the autologous group, median PFS was 6.8 months and OS 29 months. After a median follow-up of 30 months (range: 13–66 months) for the allogeneic group, median PFS was 7.3 months and OS 13 months. On univariate analysis, in the allogeneic group, an interval of greater than 1 year between the first and salvage transplants predicted a significantly better OS (p=0.02). None of the prognostic factors that were evaluated for the allogeneic group was found to have a significant impact on survival in the autologous group (which included age, cytogenetics, type of donor, and chronic graft-versus-host disease [GVHD], among others).

**Tandem Transplant**

A tandem transplant involves an autologous transplant followed by a preplanned second transplant, either another autologous or a reduced-intensity conditioning (RIC) allogeneic transplant. A tandem
transplant differs from a second salvage transplant in that a tandem transplant involves prospective planning for a second transplant at the time the first transplant is being planned.

Tandem Autologous-autologous HSCT

The first randomized trial of autologous tandem transplants (IFM-94) was published in December 2003. by Attal et al. and randomized patients with newly diagnosed myeloma to single or tandem autologous transplants. (25) Outcomes were analyzed by intention-to-treat at 75 months’ median follow-up. Among those randomized to single transplants (n=199), 148 relapsed: 33 were salvaged with a second autotransplant, 13 received no salvage, and the remainder received conventional chemotherapy plus thalidomide. Among those randomized to tandem autotransplants (n=200), 129 patients experienced disease relapse: 34 received salvage therapy with another (3rd) transplant, 12 received no salvage, and the remainder received conventional chemotherapy plus thalidomide. Seven years after diagnosis, patients randomized to tandem transplants had higher probabilities than those randomized to single transplants for event-free (EFS; 20% vs. 10%, respectively; p=0.03), relapse-free (RFS; 23% vs. 13%, respectively; p<0.01), and overall (OS; 42% vs. 21%, respectively; p=0.010) survival. Treatment-related mortality was 6% and 4% after tandem and single transplants, respectively (p=0.40). Second transplants apparently extended survival only for those who failed to achieve a CR or very good partial response (VGPR) after one transplant (OS at 7 years: 43% vs. 11%, respectively; p<0.001).

An accompanying editorial by Stadtmauer (26) raised concerns that these results might be specific to the regimens used for myeloablative therapy in IFM-94. Patients in the single transplant arm received 140 mg/m2 melphalan plus total-body irradiation (TBI), while those in the tandem arm received the same dose without TBI for the initial transplant and with TBI for the second transplant. The editorial cites an IFM-95 study as evidence, suggesting 140 mg/m2 melphalan plus TBI may be less effective and more toxic than myeloablative therapy than 200 mg/m2 melphalan and no TBI. Based on this, the author hypothesizes increased survival in the IFM-94 tandem arm may have resulted from greater cumulative exposure to melphalan (280 vs. 140 mg/m2).

The Bologna 96 clinical study, (27) compared single with double autologous HSCT (n=321). Patients undergoing tandem autologous HSCT were more likely than those with a single autologous HSCT to attain at least a near CR (47% vs. 33%, respectively; p=0.008), to prolong RFS (median, 42 vs. 24 months, respectively; p<0.001), and extend EFS (median, 35 vs. 23 months, respectively; p=0.001). There was no significant difference between the groups in TRM (3–4%). There was a trend for improved OS among patients in the double-transplantation group (7-year rate of 60%), as compared with the single-transplantation group (7-year rate of 47%; p=0.10). Conversely, among patients achieving CR or near CR after one transplantation, EFS and OS were not significantly different according to transplantation(s) received by study randomization. A subgroup analysis of outcomes of patients assigned to the two treatment arms was evaluated according to response and showed similar results to the Attal et al. study, (24) in that the benefit of a second transplant was seen only in patients who did not achieve at least a very good PR with the first transplant.

Tandem autologous/reduced-intensity conditioning (RIC) allogeneic HSCT
Three RCTs have been published comparing RIC-allogeneic HSCT following a first autologous HSCT to autologous transplants, single or in tandem. These studies were based on “genetic randomization,” that is, patients with an HLA-identical sibling were offered an RIC-allogeneic HSCT following the autologous HSCT, whereas the other patients underwent either one or two autologous.

The first published study by Garban and colleagues included high-risk patients (including deletion of chromosome 13). Sixty-five patients were in the autologous/RIC-allogeneic group and 219 in the autologous/autologous group. (28) Based on the intention-to-treat analysis, there was better median EFS and OS in the autologous/autologous group (35 months versus 31.7; p=NS and 47.2 months versus 35; p=0.07, respectively). If results for only those patients who actually received the autologous/RIC-allogeneic (n=46) or tandem autologous transplants (n=166) were analyzed, the superior OS was again seen in the tandem autologous group (median 47.2 vs. 35 months; p=0.07). Updated results of this population were reported with a reference date of July 2008 by Moreau and colleagues. (29) Comparing the results of the 166 patients who completed the whole tandem autologous HSCT protocol to the 46 patients who underwent the entire autologous/RIC-allogeneic program, no difference was seen regarding EFS (median 25 vs. 21 months, respectively; p=0.88), with a trend toward superior OS in favor of double autologous HSCT (median OS 57 vs. 41 months, respectively; p=0.08), due to a longer survival after relapse in the tandem autologous transplant arm.

One study by Bruno and colleagues included 80 patients with an HLA-identical sibling and who were allowed to choose allografts or autografts for the second transplant (58 completed an autograft/allograft sequence) and 82 without an HLA-identical sibling who were assigned to tandem autografts (46 completed the double autograft sequence). (30) The results among those completing tandem transplantation showed a higher CR rate at the completion of the second transplant for the autograft/allograft group (55%) than for the autograft/autograft group (26%; p=0.004). EFS and OS were superior for the patients who underwent autologous-allogeneic transplantation (35 months vs. 29; p=0.02 and 80 months vs. 54; p=0.01, respectively). Analyzing the group with HLA-identical siblings versus those without, in a pseudo intention-to-treat analysis, EFS and OS were significantly longer in the group with HLA-identical siblings. The treatment-related mortality rate at 2 years was 2% in the double autograft group and 10% in the autograft/allograft group; 32% of the latter group had extensive, chronic GVHD.

Rosinol and colleagues reported the results of a prospective study of 110 patients with MM who failed to achieve at least near-complete remission after a first autologous HSCT and were scheduled to receive a second autologous transplant (n=85) or an RIC-allogeneic transplant (n=25), depending on the availability of an HLA-identical sibling donor. (31) The autologous/RIC-allogeneic group had a higher CR rate (40% vs. 11%, respectively; p=0.001) and a trend toward a longer PFS (median 31 months vs. not reached, respectively; p=0.08). There was no statistical difference in EFS or OS between the two groups. The autologous/RIC-allogeneic group experienced a higher transplantation-related mortality rate (16% vs. 5%, respectively; p=0.07) and a 66% chance of chronic GVHD.

Although the results differ among the Garban/Moreau study (28,29) and the other two studies (30,31), the authors of the Moreau et al. study suggest that this is due to different study designs. The Moreau
et al. study focused on patients with high-risk disease and involved a conditioning regimen before the RIC-allogeneic transplant that may have eliminated some of the graft-versus-myeloma effect. Other contributing factors may have been non-uniform preparative regimens, different patient characteristics and criteria for advancing to a second transplant (i.e., only patients who failed to achieve a CR or near CR after the first autologous transplant underwent a second), and a small population in the allogeneic group in the Moreau et al. study. The authors suggest that the subgroup of high-risk patients with de novo MM may get equivalent or superior results with a tandem autologous/autologous transplant versus a tandem autologous/RIC-allogeneic transplant and that in patients with standard-risk and/or chemosensitive MM, RIC allograft may be an option.

The final results of 2 completed prospective Phase III trials comparing double autologous with single autologous followed by RIC-allogeneic transplant are awaited. (32,33) Interim results of the study by the HOVON Group at 36 months of follow-up found no significant difference between the groups that received autologous/RIC-allogeneic transplants or tandem autologous transplants in EFS (median 34 months and 28 months, respectively) or OS (80% and 75%, respectively) at 36 months. (32) An interim analysis of a European Group for Blood and Marrow Transplant (EBMT) study was recently presented with somewhat different inclusion criteria. (33) Previously untreated patients received vincristine, doxorubicin, dexamethasone (VAD) or VAD-like induction treatment, and had a response status of at least stable disease (i.e., complete or partial remission or stable disease) at the time of autologous transplantation, which was also the time point for study inclusion. Patients with an HLA-identical sibling proceeded to RIC-allogeneic transplantation, while those without a matched sibling received no further treatment or a second autologous stem-cell transplant (if treated within a tandem program). A total of 356 patients were included, with a median follow-up of 3.5 years. Of these, 108 patients were allocated to the RIC-allogeneic transplant group and 248 to the autologous transplant group. Of the patients allocated to the allogeneic group, 98 received a RIC-allogeneic transplant. As of now, there is no significant difference in PFS or OS between the double autologous and autologous/RIC-allogeneic transplant recipients. However, the follow-up is too short for firm conclusions to be drawn and the study is still ongoing.

An important variable in these studies is the use of different conditioning regimens. (34)

**Allogeneic SCT**

Even though myeloablative allogeneic HSCT may be the only curative treatment in MM (due to its graft-versus-myeloma effect), its use has been limited to younger patients. Even with the limited indications, the toxic death rate related to infections and GVHD is considered too high, and this strategy has been almost completely abandoned. (35)

Nonmyeloablative conditioning (RIC) methods have since been used. Most studies are Phase II studies with no comparison to other treatment modalities. (36) One retrospective study compared myeloablative and non-myeloablative conditioning. (37) This study, conducted by the EBMT, found that transplant-related mortality was significantly reduced with RIC but because of a higher relapse/progression rate, there was no significant improvement in OS.
When RIC-allogeneic transplant alone is used in patients with a high tumor burden or with chemotherapy-resistant disease, the immunologic effect of the graft is not sufficient to avoid relapses. (34) Therefore, RIC-allogeneic transplantation is currently used after tumor mass reduction with high-dose chemotherapy and autologous HSCT. (35)

Future direction

Despite the recent advances in the treatment of MM, with new drugs and drug combinations, autologous HSCT and reduced-intensity allografts, it remains an incurable disease. Future challenges will be how to integrate the best combinations of new and old drugs for initial induction treatments, conditioning regimens, and postinduction maintenance.

Professional Society Recommendations

Treatment of Newly Diagnosed Multiple Myeloma Based on Mayo Stratification of Myeloma and Risk-Adapted Therapy (mSMART):

If the patient is considered transplant eligible (off-study), risk status should be determined. If the patient is standard risk, after induction therapy, autologous HSCT is recommended (with the option to continue induction therapy if response is good). If patient is not in CR or very good PR after the first autologous HSCT, a second autologous HSCT may be considered. In patients considered high risk, if after 4 cycles of bortezomib, lenalidomide, and dexamethasone, (especially if the patient is not in CR), autologous HSCT is recommended.

Treatment of Relapsed Multiple Myeloma Based on Mayo Stratification of Myeloma and Risk-Adapted Therapy (mSMART):

If the patient is considered transplant eligible (off-study), risk status should be determined. If the patient is standard risk and relapsed after autologous transplant, repeat autologous transplant is an option, after a bortezomib or immunomodulatory derivative-containing regimen. If the standard-risk patient is relapsed after conventional chemotherapy, the recommendation is to proceed to autologous HSCT or to repeat the previous regimen to maximum response or 1 year. If the patient is high risk and relapses after an autologous transplant, an autologous followed by an allogeneic transplant is an option in selected patients. If a high-risk patient relapses after bortezomib or immunomodulatory-based initial therapy, autotransplant (followed by allogeneic in selected patients), is recommended.

International Myeloma Working Group Consensus Statement regarding the current status of allogeneic stem-cell transplantation for multiple myeloma (38)

The conclusions and recommendations are as follows: Myeloablative allogeneic HSCT may cure a minority of patients, but is associated with a high transplant-related mortality (TRM), but could be evaluated in well-designed prospective clinical trials. Nonmyeloablative allogeneic HSCT as first-line
therapy is associated with lower TRM but a greater risk of relapse, and convincing evidence is lacking that allogeneic HSCT improves survival as compared to autologous HSCT.

National Comprehensive Cancer Network (NCCN) Practice Guidelines 2011 (39)

**Autologous single transplant:**

Autologous HSCT is considered a category 1 recommendation as follow-up to induction therapy for newly diagnosed MM and as a category 1 recommendation for relapsed or progressive disease if the patient is considered a transplant candidate.

**Tandem autologous-autologous transplant:**

The NCCN Myeloma panel recommends collecting enough stem cells for two transplants in all eligible patients. A tandem transplant can be considered for all patients who are candidates for HSCT, and is an option for patients who do not achieve at least a VGPR after the first autologous HSCT. (category 2A)

**Allogeneic transplant:**

National Comprehensive Cancer Network guidelines consider myeloablative allogeneic HSCT as an accepted option in the setting of a clinical trial (category 2A) in patients with responsive or primary progressive disease or as salvage therapy in patients with progressive disease following an initial autologous HSCT. Allogeneic HSCT may include nonmyeloablative allogeneic HSCT following an autologous HSCT (category 2A) or myeloablative allogeneic HSCT on a clinical trial (off trial category 3). Current data do not support nonmyeloablative allogeneic HSCT alone.

National Cancer Institute’s Clinical Trial Database

A search of the National Cancer Institute’s database of clinical trials identified the following Phase III trials addressing HSCT and a comparator in the treatment of myeloma: second autologous HSCT versus low-dose consolidation therapy after relapse (NCT00747877), risk-adapted therapy (NCT00546988), tandem transplantation (NCT00670631), single autologous HSCT and maintenance versus tandem autologous HSCT and maintenance therapy (NCT01109004), autologous versus allogeneic HSCT (Phase II/III; NCT00998270), single versus tandem autologous HSCT (NCT01208766), conventional-dose induction therapy followed by maintenance versus high-dose therapy with autologous HSCT in the initial treatment of myeloma (NCT01191060) and comparison of the drug combination of lenalidomide, bortezomib and dexamethasone with or without HSCT in newly diagnosed myeloma (NCT01208662).

Physician Specialty Society and Academic Medical Center Input (December 2009)

In response to requests, input was received from 2 academic medical centers while this policy was under review in 2009. While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by
the physician specialty societies or academic medical centers, unless otherwise noted. One reviewer agreed with the current policy statement related to tandem autologous/RIC-allogeneic and the other disagreed. Those providing input agreed with the other policy statements. (The conclusion that allogeneic HSCT is investigational for salvage therapy was a late addition to the policy and was not sent for clinical input.)

VI. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

VII. References

7. Blue Cross and Blue Shield Association Technology Evaluation Center (TEC). Allogeneic Bone Marrow Transplantation for Multiple Myeloma. TEC Assessments 1996; Volume 11, Tab 28.