

**8.01.17 Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma and POEMS Syndrome****Original Policy Date:** January 7, 2011**Effective Date:** April 1, 2024**Section:** 11.0 Transplant**Page:** Page 1 of 33**Policy Statement****Multiple Myeloma**

- I. A single or second (salvage) autologous hematopoietic cell transplantation may be considered **medically necessary** to treat multiple myeloma.
- II. Tandem autologous hematopoietic cell transplantation may be considered **medically necessary** to treat multiple myeloma in individuals 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 section.)
- III. Tandem transplantation with an initial round of autologous hematopoietic cell transplantation followed by a non-marrow-ablative conditioning regimen and allogeneic hematopoietic stem cell transplantation (i.e., reduced-intensity conditioning transplant) may be considered **medically necessary** to treat newly diagnosed multiple myeloma individuals.
- IV. Allogeneic hematopoietic cell transplantation, myeloablative or nonmyeloablative, as initial therapy of newly diagnosed multiple myeloma or as salvage therapy, is considered **investigational**.

**POEMS Syndrome**

- V. Autologous hematopoietic cell transplantation may be considered **medically necessary** to treat disseminated POEMS syndrome (see Policy Guidelines section).
- VI. Allogeneic and tandem hematopoietic cell transplantation are considered **investigational** to treat POEMS syndrome.

**NOTE:** Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

**Policy Guidelines**

The International Working Group on Myeloma has updated the European Group for Blood and Marrow Transplant criteria to describe a complete response to multiple myeloma therapy. The criteria include negative immunofixation on the serum and urine; disappearance of soft tissue plasmacytomas; and 5% or fewer plasma cells in bone marrow aspiration.

Individuals with disseminated POEMS syndrome may have diffuse sclerotic lesions or disseminated bone marrow involvement.

**Coding**

CPT grouped codes describing allogeneic and autologous hematopoietic cell therapy (HCT) services to the hematology section (CPT 38204-38242). Not all codes are applicable for each HCT procedure. For example, Plans should determine if cryopreservation is performed. A range of codes describes services associated with cryopreservation, storage, and thawing of cells (38207-38215).

The following CPT code describes cryopreservation and storage:

- **38207:** Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage

The following codes describe thawing and washing of cryopreserved cells:

- **38208:** Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor
- **38209:** Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor

The following CPT codes describe certain cell types being depleted:

- **38210:** Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion
- **38211:** Transplant preparation of hematopoietic progenitor cells; tumor cell depletion
- **38212:** Transplant preparation of hematopoietic progenitor cells; red blood cell removal
- **38213:** Transplant preparation of hematopoietic progenitor cells; platelet depletion
- **38214:** Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion

The following CPT code describes plasma cell concentration:

- **38215:** Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer

## Description

Multiple myeloma (MM) is a systemic malignancy of plasma cells that represents approximately 10% of all hematologic cancers. POEMS syndrome, characterized by polyneuropathy, organomegaly, endocrinopathy, M protein, and skin changes, is a rare, paraneoplastic disorder secondary to a plasma cell dyscrasia. Plasma cell dyscrasias are treatable but rarely curable. In some cases, autologous or allogeneic hematopoietic cell transplantation (HCT) is considered as therapy.

## Related Policies

- N/A

## Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibit plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

## Regulatory Status

The U.S. Food and Drug Administration regulates human cells and tissues intended for implantation, transplantation, or infusion through the Center for Biologics Evaluation and Research, under Code of Federal Regulation, Title 21, parts 1270 and 1271. Hematopoietic stem cells are included in these regulations.

## Rationale

### Background

#### Multiple Myeloma

Multiple myeloma (MM) is a systemic malignancy of plasma cells that represents approximately 18% of all hematologic cancers in the United States. It is treatable but rarely curable. At diagnosis, most patients have generalized disease, and the selection of treatment is influenced by patient age, general health, prior therapy, and the presence of disease complications.<sup>1,2,3,4</sup>

The disease is staged by estimating tumor mass, based on various clinical parameters such as hemoglobin, serum calcium, number of lytic bone lesions, and the presence or absence of renal failure. Multiple myeloma usually evolves from an asymptomatic premalignant stage (termed *monoclonal gammopathy of undetermined significance*). Treatment is usually reserved for patients with symptomatic disease (usually progressive myeloma), whereas asymptomatic patients are observed because there is little evidence that early treatment of asymptomatic MM prolongs survival compared with therapy delivered at the time of symptoms or end-organ damage.<sup>1,2</sup> In some patients, an intermediate asymptomatic but more advanced premalignant stage is recognized and referred to as smoldering MM. The overall risk of disease progression from smoldering to symptomatic MM 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.<sup>1,2</sup>

#### Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal gammopathy, and Skin abnormalities (POEMS) Syndrome

POEMS syndrome (also known as osteosclerotic myeloma, Crow-Fukase syndrome, or Takatsuki syndrome) is a rare, paraneoplastic disorder secondary to a plasma cell dyscrasia.<sup>5,6</sup> This complex, multiorgan disease was first described in 1938, but the acronym POEMS was coined in 1980, reflecting hallmark characteristics of the syndrome: polyneuropathy, organomegaly, endocrinopathy, M protein, and skin changes.<sup>7</sup> No single test establishes the presence of POEMS syndrome. Its pathogenesis is undefined, although some evidence has suggested it is mediated by an imbalance of proinflammatory cytokines including interleukin (IL)-1 $\beta$ , IL-6, and tumor necrosis factor  $\alpha$ ; vascular endothelial growth factor may also be involved.<sup>6,8</sup> However, specific criteria have been established, and the syndrome may entail other findings in the constellation of signs and symptoms, as shown in Table 1.<sup>9</sup> Both mandatory major criteria, at least 1 of the other major criteria, and at least 1 of the minor criteria are necessary for diagnosis.

**Table 1. Criteria and Associations for POEMS Syndrome**

Mandatory Major Criteria	Other Major Criteria	Minor Criteria	Other Symptoms and Signs
<b>Polyneuropathy</b>	Castleman disease	Organomegaly (splenomegaly, hepatomegaly, lymphadenopathy)	Pulmonary hypertension/restrictive lung disease
<b>Monoclonal plasma-proliferative disorder</b>	Sclerotic bone lesions	Extravascular volume overload (edema, pleural effusion, ascites)	Clubbing
	Vascular endothelial growth factor elevation	Endocrinopathy (adrenal, thyroid, pituitary, gonadal, parathyroid, pancreatic)	Thrombotic diatheses
		Skin changes (hyperpigmentation, hypertrichosis, plethora, hemangiomas, white nails)	Weight loss
		Papilledema	Low vitamin B <sub>12</sub> levels

Mandatory Major Criteria	Other Major Criteria	Minor Criteria	Other Symptoms and Signs
		Thrombocytosis /polycythemia	Diarrhea
			Hyperhidrosis

The prevalence of POEMS syndrome is unclear. A national survey in Japan showed a prevalence of about 0.3 per 100,000.<sup>10</sup> Other large series have been described in the United States, France, China, and India.<sup>9</sup> In general, patients with POEMS have superior overall survival (OS) compared with that of MM (nearly 14 years in a large series).<sup>8</sup> However, given the rarity of POEMS, there is a paucity of randomized controlled trial (RCT) evidence for POEMS therapies.<sup>9</sup> Numerous approaches have been tried, including ionizing radiation, plasmapheresis, intravenous immunoglobulin, interferon- $\alpha$ , corticosteroids, alkylating agents, tamoxifen, trans-retinoic acid, and high-dose chemotherapy with autologous hematopoietic cell transplantation (HCT) support. Optimal treatment involves eliminating the plasma cell clone (e.g., by surgical excision or local radiotherapy for an isolated plasmacytoma) or systemic chemotherapy in patients with disseminated disease (e.g., medullary disease or multiple plasmacytomas). Given the underlying plasma cell dyscrasia of POEMS syndrome, newer approaches to MM, including bortezomib, lenalidomide, and thalidomide, have also been investigated.

### 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]). They can be harvested from bone marrow, peripheral blood, or umbilical cord blood shortly after delivery of neonates. Cord blood transplantation is discussed in detail in evidence review 7.01.50.

Immunologic compatibility between infused hematopoietic stem cells and the recipient is not an issue in autologous HCT. In allo-HCT, 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. HLA 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 cytotoxic drugs. Subsequent to graft infusion in allo-HCT, immunosuppressant drugs are required to minimize graft rejection and graft-versus-host disease, 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 graft-versus-host disease.

### **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.

### **Multiple Myeloma Treatment Overview**

In the prechemotherapy era, the median survival for a patient diagnosed with MM 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 to 30 months and 10-year survival of 3%. In a large group of patients with newly diagnosed MM, there was no difference in OS reported during a 24-year period from 1971 to 1994, with a trend toward improvement from 1995 to 2000, and a statistically significant benefit in OS from 2001 to 2006.<sup>2</sup> These data suggested that autologous HCT was responsible for the trends from 1994 to 2000, while novel agents have contributed to the improvement since 2001.

The introduction of novel agents and better prognostic indicators has been the major advances in the treatment of this disease.<sup>11</sup> Novel agents such as the proteasome inhibitors (e.g., bortezomib), the monoclonal antibody daratumumab, and the immunomodulatory derivatives thalidomide and lenalidomide first showed efficacy in relapsed and refractory myeloma and now have been integrated into first-line regimens.<sup>11,12,13</sup> With the introduction of these novel treatments, it is now expected that most patients with MM will respond to initial therapy, and only a small minority will have refractory disease.<sup>14</sup>

### **Literature Review**

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms. To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent 1 or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. Randomized controlled trials are rarely large enough or long enough to capture less common adverse events and long-term effects.

Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Promotion of greater diversity and inclusion in clinical research of historically marginalized groups (e.g., People of Color [African-American, Asian, Black, Latino and Native American]; LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual); Women; and People with Disabilities [Physical and Invisible]) allows policy populations to be more reflective of and findings more applicable to our diverse members. While we also strive to use inclusive language related to these groups in our policies, use of gender-specific nouns (e.g., women, men, sisters, etc.) will continue when reflective of language used in publications describing study populations.

### **Newly Diagnosed Multiple Myeloma Risk-Adapted Therapy**

The approach to the treatment of newly diagnosed multiple myeloma (MM) (symptomatic) is dictated by eligibility for autologous hematopoietic cell transplantation (HCT) and risk stratification.<sup>13</sup> Risk stratification, using fluorescent in situ hybridization and conventional karyotyping divides patients into high- or standard-risk categories.

High-risk patients, which comprise approximately 25% of patients with MM, are defined by any of the following cytogenetic findings: a 17p deletion; translocations of chromosomes 4 and 14, chromosomes 14 and 16, chromosomes 14 and 20; or a 1q gain.<sup>15</sup> Standard-risk patients are those with hyperdiploidy (translocations of chromosomes 11 and 14 and chromosomes 6 and 14).

High-risk patients are generally treated with a bortezomib-based induction followed by autologous HCT and then bortezomib-based maintenance.<sup>15</sup> Standard-risk patients are typically treated with bortezomib-based induction therapy followed by autologous HCT and then maintenance with lenalidomide; however, if the patient is tolerating the induction regimen well, an alternative strategy would be to continue the initial therapy after hematopoietic cell collection, reserving the transplant for the first relapse.

### **Autologous Hematopoietic Cell Transplantation Versus Standard Chemotherapy Clinical Context and Therapy Purpose**

The purpose of autologous HCT as initial treatment in individuals who have newly diagnosed MM is to provide a treatment option that is an alternative to or an improvement on existing therapies. The following PICO was used to select literature to inform this review.

#### ***Populations***

The relevant population of interest is individuals with newly diagnosed MM.

#### ***Interventions***

The therapy being considered is autologous HCT as initial treatment.

#### ***Comparators***

The following therapies are currently being used to make decisions about newly diagnosed MM: conventional chemotherapy with or without novel therapies.

#### ***Outcomes***

The general outcomes of interest are overall survival (OS) and treatment-related morbidity. Follow-up over months to years is of interest to monitor outcomes.

### **Study Selection Criteria**

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;

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

## Review of Evidence

### Systematic Reviews

A systematic review and meta-analysis by Mian et al (2020) specifically sought to examine the impact of autologous HCT in patients aged 65 years or older with newly-diagnosed MM.<sup>16</sup> This review included data from 2 RCTs and 6 observational studies. In a pooled analysis of the observational studies, autologous HCT was associated with favorable effects on OS compared to non-HCT therapy (hazard ratio [HR], 0.44; 95% confidence interval [CI], 0.34 to 0.58;  $p < .0001$ ). However, in the pooled analysis of RCT data, the impact of autologous HCT on OS was uncertain (HR, 0.94; 95% CI, 0.25 to 3.54,  $p = .93$ ). Observational data also showed higher complete response (CR) rates with autologous HCT (odds ratio [OR], 5.06; 95% CI, 2.60 to 9.88;  $p < .0001$ ). The authors of the review concluded that autologous HCT may improve the OS and CR rates in elderly patients based on observational data, but the quality of the evidence is very low, and more studies are needed.

A systematic review by Koreth et al (2007) of 2411 patients enrolled in RCTs compared standard-dose chemotherapy with myeloablative chemotherapy plus single autologous HCT.<sup>17</sup> Meta-analysis concluded that myeloablative therapy with autologous HCT increased the likelihood of progression-free survival (PFS) (HR of progression, 0.75; 95% CI, 0.59 to 0.96) but not OS (HR of death, 0.92; 95% CI, 0.74 to 1.13); in this group, the OR for treatment-related mortality was 3.01 (95% CI, 1.64 to 5.50). However, the effects of myeloablative chemotherapy and autologous HCT might have been underestimated because up to 55% of patients in the standard chemotherapy group received myeloablative chemotherapy with autologous HCT as salvage therapy when MM progressed. This could account for the lack of a significant difference in OS between the 2 groups.

### Randomized Controlled Trials

Several RCTs have compared autologous HCT with treatment regimens that utilize newer MM agents. Richardson et al (2022) conducted a US-based, multicenter, open-label RCT comparing lenalidomide, bortezomib, and dexamethasone alone with the lenalidomide, bortezomib, and dexamethasone regimen in addition to autologous HCT plus melphalan in patients with newly diagnosed multiple myeloma.<sup>18</sup> All patients received daily maintenance lenalidomide until disease progression, unacceptable toxicity, or withdrawal from treatment or the trial. Patients treated with chemotherapy alone ( $n = 357$ ) had lower median PFS (46.2 months) compared with those who received chemotherapy and autologous HCT ( $n = 365$ ; 67.5 months). Patients who received chemotherapy only had higher rates of disease progression or death at a median follow-up of 76 months (HR, 1.53; 95% CI, 1.23 to 1.91;  $p < .001$ ). Overall survival was similar between groups. Grade 3 or higher treatment-related adverse events were higher in patients undergoing HCT (94.2% vs. 78.2%).

Cavo et al (2020) conducted a multicenter, randomized, open-label phase 3 study comparing standard-dose intensification therapy with bortezomib, melphalan, and prednisone ( $n = 495$ ) to high-dose melphalan plus autologous HCT ( $n = 702$ ) in patients with newly diagnosed MM (up to 65 years of age).<sup>19</sup> Within the autologous HCT group, 492 received a single autologous HCT and 210 received a double autologous HCT. Median PFS was 56.7 months (95% CI, 49.3 to 64.5) for patients receiving autologous HCT versus 41.9 months (95% CI, 37.5 to 46.9) for those assigned to standard-dose intensification therapy (HR, 0.73; 95% CI, 0.62 to 0.85;  $p = .0001$ ). The 5-year OS rate was 75.1% (95% CI, 71.7 to 78.5) for patients in the autologous HCT group and 71.6% (95% CI, 67.4 to 76.1) for those in the standard-dose intensification therapy group (HR, 0.90; 95% CI, 0.71 to 1.13;  $p = .35$ ). Among patients with high-risk cytogenetic profiles, OS was significantly better with autologous HCT.

Attal et al (2017) conducted a randomized, open-label phase 3 trial in patients less than 65 years of age with newly diagnosed MM.<sup>20</sup> Patients were randomly assigned to receive consolidation therapy

with 5 cycles of bortezomib, lenalidomide, and dexamethasone (n=350) or high-dose melphalan followed by autologous HCT and 2 cycles of bortezomib, lenalidomide, and dexamethasone (n=350). With a median follow-up of 43 months, median PFS was 36 months in the non-transplant group versus 50 months in the transplant group (HR, 0.65;  $p<.001$ ). The 4-year PFS rates were 35% and 50% for non-transplant and transplant groups respectively ( $p<.001$ ), while 4-year OS rates were 82% and 81%, respectively ( $p=.43$ ). Median OS was not reached for either group.

An RCT by Gay et al (2015) compared autologous HCT with standard chemotherapy plus lenalidomide.<sup>21</sup> The open-label RCT from 59 centers in Europe and Australia used a 2x2 factorial design to compare 4 groups: (1) standard consolidation therapy plus HCT, followed by maintenance with lenalidomide alone, (2) standard consolidation therapy plus HCT, followed by maintenance with lenalidomide and prednisone, (3) consolidation with chemotherapy plus lenalidomide, followed by maintenance with lenalidomide alone, and (4) consolidation with chemotherapy plus lenalidomide, followed by maintenance with lenalidomide plus prednisone. The primary outcome was PFS. Mean follow-up at the time of publication was 52 months. Median PFS was superior for the HCT group plus standard consolidation (43.3 months; 95% CI, 33.2 to 52.2 months) compared with chemotherapy plus lenalidomide (28.6 months; 95% CI, 20.6 to 36.7 months;  $p<.0001$ ). The rate of grade 3 or 4 adverse events was higher in the HCT groups than in the chemotherapy groups (hematologic events, 84% vs. 26%; gastrointestinal complications, 20% vs. 5%; infections, 19% vs. 5%; all respectively). Based on several prospective, randomized trials comparing conventional chemotherapy with high-dose therapy plus autologous HCT for patients with MM, autologous HCT has become the treatment of choice in patients younger than 65 years of age.

Data from 7 randomized studies are available.<sup>22,23,24,25,26,27,28</sup> In all but 1 study (Barlogie et al [2006]),<sup>24</sup> the CR rate was superior in the high-dose chemotherapy plus autologous HCT arm. The Barlogie et al (2006) study published final results from the phase 3 S9321 trial, which was initiated in 1993 and randomized 516 patients with MM to standard therapy or myeloablative conditioning with melphalan 140 mg/m<sup>2</sup> plus total body irradiation (TBI) followed by autologous HCT. These trialists reported virtually no difference in outcomes, including response rates, PFS, and OS. In 5 of the 7 studies, the superior CR rate translated into significant increases in PFS. However, in the 2 studies that did not show an improved PFS with autologous HCT, randomization was not performed at diagnosis but only after induction treatment, possibly introducing selection bias.<sup>22</sup> Three of the 7 studies showed superior OS in the autologous HCT group.<sup>23,26,28</sup>

The Intergroupe Francophone du Myélome (IFM) showed the superiority of high-dose chemotherapy plus autologous HCT compared with conventional chemotherapy in a 1996 randomized trial of 200 patients younger than 65 years of age.<sup>23</sup> The group that underwent autologous HCT had significantly improved response rates, event-free survival (EFS), and OS. Seven years later, the British Medical Research Council published similar results.<sup>26</sup>

### Retrospective Studies

Marini et al (2019) published a retrospective study of elderly (age  $\geq 65$  years) MM patients treated with autologous stem cell transplantation (ASCT) at a single Portuguese center between 2010 and 2016.<sup>29</sup> The median follow-up for ASCT (n=132) patients and controls (n=23), who did not receive transplantation, was 30 months. The overall transplant-related mortality rate was 3.8%, and ASCT had a higher survival rate than the control group (OS, 59 and 30 months, respectively;  $p=.037$ ; EFS, 45 and 27 months, respectively;  $p=.014$ ). The study was limited by its retrospective nature, lack of randomization, and the subjective categorization for transplant of patients.

### Section Summary: Autologous Hematopoietic Cell Transplantation Versus Standard Chemotherapy

For individuals with newly diagnosed MM, evidence from multiple RCTs has suggested that high-dose chemotherapy with autologous HCT is superior to standard chemotherapy in PFS, and possibly OS. More recent RCTs comparing high-dose melphalan plus autologous HCT to chemotherapy



regimens that include novel agents have also shown that high-dose melphalan plus autologous HCT improves PFS.

## **Tandem Hematopoietic Cell Transplantation**

### **Clinical Context and Therapy Purpose**

The purpose of tandem autologous HCT in individuals who have newly diagnosed MM is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

### ***Populations***

The relevant population of interest is individuals with newly diagnosed MM.

### ***Interventions***

The therapy being considered is tandem autologous HCT. Tandem HCT involves an autologous transplant followed by a preplanned second transplant, either another autologous or 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.

### ***Comparators***

The following therapies are currently being used to make decisions about newly diagnosed MM: conventional chemotherapy with or without novel therapies.

### ***Outcomes***

The general outcomes of interest are OS and treatment-related morbidity.

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

## **Study Selection Criteria**

Methodologically credible studies were selected using the following principles:

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

## **Review of Evidence**

### **Tandem Autologous Hematopoietic Cell Transplantation**

#### **Randomized Controlled Trials**

The first randomized trial of tandem autologous transplants, Single versus Double Autologous Stem-Cell Transplantation for Multiple Myeloma (IFM-94) was published by Attal et al (2003).<sup>30</sup> This trial randomized patients with newly diagnosed myeloma to single or tandem autologous transplants. Outcomes were analyzed by intent to treat (ITT) at 75-month 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 (third) 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 EFS (20% vs. 10%; p=.03), relapse-free survival (23% vs. 13%; p<.01), and OS (42% vs.

21%;  $p=.010$ ), all respectively. Treatment-related mortality rates were 6% and 4% after tandem and single transplants, respectively ( $p=.40$ ). Second transplants extended survival only for those who failed to achieve a CR or without a very good partial response after 1 transplant (OS at 7 years, 43% vs. 11%, respectively;  $p<.001$ ).

An accompanying editorial by Stadtmauer (2003) raised concerns that IFM-94 results might be specific to the regimens used for myeloablative therapy.<sup>31</sup> Patients in the single transplant arm received melphalan 140 mg/m<sup>2</sup> plus 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 cited the IFM-95 study as evidence, suggesting melphalan 140 mg/m<sup>2</sup> plus TBI may be less effective and more toxic than myeloablative therapy plus melphalan 200 mg/m<sup>2</sup> and no TBI. Based on this, Stadtmauer (2003) hypothesized that increased survival in the IFM-94 tandem arm might have resulted from greater cumulative exposure to melphalan (280 mg/m<sup>2</sup> vs. 140 mg/m<sup>2</sup>).

The Prospective, Randomized Study of Single Compared With Double Autologous Stem-Cell Transplantation for Multiple Myeloma (Bologna 96) clinical study (2007) assessed single and double autologous HCT (N=321).<sup>32</sup> Patients undergoing tandem autologous HCT were more likely than those with a single autologous HCT to attain at least a near CR (47% vs. 33%;  $p=.008$ ), to prolong relapse-free survival (median, 42 months vs. 24 months;  $p<.001$ ), and extend EFS (median, 35 months vs. 23 months;  $p=.001$ ), all respectively. There was no significant difference between groups in treatment-related mortality (3% to 4%). There was a trend for improved OS among patients in the double transplant group (7-year rate, 60%) compared with the single transplant group (7-year rate, 47%;  $p=.10$ ). Conversely, among patients achieving CR or near CR after 1 transplant, EFS and OS estimates did not differ significantly according to transplant(s) received by study randomization. A subgroup analysis of outcomes of patients assigned to the 2 treatment arms, conducted by treatment response, showed that the benefit of a second transplant was particularly evident in patients who failed to achieve at least near CR after the first autologous transplant.

In the RCT by Cavo et al (2020) described in the section above, patients who were assigned to receive autologous HCT at a center that performed double autologous HCT were randomly assigned to receive either single (n=209) or double (n=210) autologous HCT.<sup>19</sup> Outcomes were compared between these subgroups in a secondary analysis. Double autologous HCT significantly improved rates of 5-year PFS (53.5% vs. 44.9%; HR, 0.74; 95% CI, 0.56 to 0.98;  $p=.036$ ) and 5-year OS (80.3% vs. 72.6%; HR, 0.62; 95% CI, 0.41 to 0.93;  $p=.022$ ) compared to single autologous HCT. Patients with high-risk cytogenetic profiles appeared to attain a greater magnitude of benefit with double HCT versus single HCT, compared to patients with standard-risk profiles.

Stadtmauer et al (2019) reported a randomized phase 3 study in patients with symptomatic MM who received at least 2 cycles of any regimen as initial systemic therapy without disease progression and who were within 2 to 12 months of the first dose of initial therapy.<sup>33</sup> Patients were randomly assigned to 1 of 3 treatment arms: autologous HCT (n=257), tandem autologous HCT (n=247), or autologous HCT plus 4 cycles of lenalidomide, bortezomib, and dexamethasone (n=254). Rates of 38-month PFS were similar across groups (58.5%, 57.8%, and 53.9% for tandem HCT, autologous HCT plus lenalidomide/bortezomib/dexamethasone, and autologous HCT respectively), as were rates of 38-month OS (81.8%, 85.4%, and 83.7%, respectively). However, 32% of patients in the tandem group did not receive the second HCT. Results of this study differed from those of the Cavo et al study described above. This may be related to differences in initial therapy; in the Cavo et al study, patients received a prespecified number of induction therapy cycles that did not include immunomodulatory agents (e.g., lenalidomide), while the majority of patients in this study received immunomodulatory agents as part of their initial therapy prior to transplant. Additionally, more patients in the Cavo et al study underwent tandem HCT as assigned (only 20% did not receive the second transplant).<sup>19</sup>

The results of a 5-year follow-up of the trial by Stadtmauer et al (2019) were posted to Clinicaltrials.gov (NCT02322320) but have not been identified in a peer-reviewed journal.<sup>34</sup> Per

Clinicaltrials.gov, the proportion of patients achieving PFS was similar for autologous HCT (45%), tandem autologous HCT (47.7%), and autologous HCT plus lenalidomide, bortezomib, and dexamethasone (44.1%); pairwise comparisons between treatment arms did not reach statistical significance. Likewise, the proportion of patients achieving OS was similar for autologous HCT (76.4%), tandem autologous HCT (74.7%), and autologous HCT plus lenalidomide, bortezomib, and dexamethasone (75.4%); pairwise comparisons between treatment arms did not reach statistical significance.

### **Retrospective Study**

Villalba et al (2022) analyzed data from 35 hospitals in the Spanish Myeloma Group.<sup>35</sup> Patients (N=213) with newly diagnosed multiple myeloma and high-risk cytogenetics underwent single (n=142) or tandem (n=71) autologous HCT. At a median follow-up of 31 months, PFS was nonsignificantly longer with tandem HCT compared with single HCT (48 vs. 41 months;  $p=.33$ ). Patients receiving tandem HCT were younger, had more advanced stage disease, and a higher plasma cell infiltration at diagnosis. More patients in the single-transplant group died by the time of analysis than those undergoing tandem transplant although this was not statistically significant (23% vs. 12.7%;  $p=.09$ ). The authors concluded that tandem HCT partly overcomes the poor prognosis of high-risk cytogenetics when compared with a single HCT but noted further study is needed.

### **Subsection Summary: Tandem Autologous Hematopoietic Cell Transplantation**

Compared with single autologous HCT, RCTs have generally found that tandem autologous HCT improves OS and recurrence-free survival in newly diagnosed MM. Two recent RCTs found conflicting results on the benefit of tandem autologous HCT versus single autologous HCT; however, the study that found no additional benefit with tandem autologous HCT had a higher rate of nonadherence to the second planned HCT. Differences in initial therapy regimens between trials may also have led to conflicting results.

### **Tandem Autologous Hematopoietic Cell Transplantation Followed by Reduced-Intensity Conditioning and Allogeneic Hematopoietic Cell Transplantation**

#### **Randomized Controlled Trials**

Several trials have evaluated RIC allogeneic HCT (allo-HCT) following single or tandem autologous HCT. These trials were based on genetic randomization (i.e., patients with a human leukocyte antigen [HLA]-identical sibling who were offered RIC allo-HCT following the autologous HCT), whereas the other patients underwent either single or tandem autologous transplants.

The first, published by Garban et al (2006), included high-risk patients.<sup>36</sup> Sixty-five patients were in the autologous followed by RIC allogeneic group and 219 in the tandem autologous (autologous plus autologous) HCT group. Based on the ITT analysis, there was better median EFS and OS in the tandem autologous HCT group than in the RIC allo-HCT group (35 months vs. 31.7 months,  $p$ -value not significant; 47.2 months vs. 35 months,  $p=.07$ , respectively). If results for only those patients who received autologous HCT followed by RIC allo-HCT ( $n=46$ ) or tandem autologous HCT ( $n=166$ ) were analyzed, the superior OS was again seen in the tandem autologous group (median, 47.2 months vs. 35 months;  $p=.07$ ). Updated results from this population were reported by Moreau et al (2008).<sup>37</sup> Comparing the results of the 166 patients who completed the whole tandem autologous HCT protocol with the 46 patients who underwent the entire autologous followed by RIC allogeneic program, no difference was seen in median EFS (25 months vs. 21 months, respectively;  $p=.88$ ), with a trend toward superior median OS in favor of double autologous HCT (57 months vs. 41 months, respectively;  $p=.08$ ), due to longer survival after relapse in the tandem autologous transplant arm.

A study by Bruno et al (2007) included 80 patients with an HLA-identical sibling who were allowed to choose allografts or autografts for the second transplant (58 completed an autograft or allograft sequence) and 82 without an HLA-identical sibling who were assigned to tandem autografts (46 completed the double autograft sequence).<sup>38</sup> Results among those completing tandem transplantation showed a higher CR rate after the second transplant for the autologous plus allo-

HCT group (55%) than for the tandem autologous HCT group (26%;  $p=.004$ ). Additionally, EFS and OS were superior for patients who underwent autologous plus allogeneic transplantation than for the tandem autologous transplantation (35 months vs. 29 months;  $p=.02$ ; 80 months vs. 54 months;  $p=.01$ , respectively). Comparing the group who had HLA-identical siblings with those without, in a pseudo-ITT 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 tandem autologous group and 10% in the autologous plus allogeneic group; 32% of the latter group had extensive, chronic graft-versus-host disease (GVHD).

Rosinol et al (2008) reported on the results of a prospective study of 110 patients with MM who failed to achieve at least near CR after a first autologous HCT 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.<sup>39</sup> The autologous followed by RIC allogeneic group had a higher CR rate (40% vs. 11%, respectively;  $p=.001$ ) and a trend toward a longer median PFS (31 months vs. not reached, respectively;  $p=.08$ ). There were no statistical differences in EFS or OS estimates between groups. The autologous followed by RIC allogeneic group experienced a higher treatment-related mortality rate (16% vs. 5%, respectively;  $p=.07$ ) and had a 66% chance of chronic GVHD.

Although results differed between the Garban et al (2006) and Moreau et al (2008) studies<sup>36,37</sup>, and the Bruno et al (2007) and Rosinol et al (2008) studies,<sup>38,39</sup> these differences might have been due to study designs. The Moreau et al (2008) study focused on patients with high-risk disease and involved a conditioning regimen before the RIC allogeneic transplant that might have eliminated some of the graft-versus-myeloma effects. Other contributing factors might have been nonuniform 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 (2008) study. Reviewers suggested that the subgroup of high-risk patients with de novo MM might have had equivalent or superior results with a tandem autologous HCT versus a tandem autologous plus RIC allo-HCT and that, in patients with standard-risk and/or chemosensitive MM, RIC allograft might be an option.

An interim analysis of a prospective study by the European Group for Blood and Marrow Transplant (EBMT) (2008) was presented as a meeting abstract.<sup>40</sup> Previously untreated patients received vincristine, doxorubicin, and dexamethasone or vincristine, doxorubicin, and dexamethasone-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 allo-HCT, while those without a matched sibling received no further treatment or a second autologous cell transplant (if treated with 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 allo-HCT group and 248 to the autologous transplant group. Of patients allocated to the allogeneic group, 98 received a RIC allogeneic transplant. At interim reporting, no significant differences in PFS or OS estimates were noted between groups.

Additional results from the EBMT trial were published by Gahrton et al (2013).<sup>41</sup> At 96 months, PFS and OS rates were 22% and 49% versus 12% ( $p=.027$ ) and 36% ( $p=.030$ ) for tandem autologous plus RIC allo-HCT versus autologous HCT, respectively. The corresponding relapse or progression rates were 60% and 82% ( $p<.001$ ), respectively. Non-relapse mortality rates at 36 months were 13% and 3% ( $p<.001$ ), respectively. In patients with the chromosome 13 deletion, corresponding PFS and OS estimates were 21% and 5% ( $p=.026$ ) and 47% and 31% ( $p=.154$ ), respectively. Long-term outcomes in patients with MM were better with autologous HCT followed by RIC allo-HCT than with autologous HCT only, and the autologous followed by RIC allogeneic approach seemed to overcome the poor prognostic impact of chromosome 13 deletion observed after autologous transplantation.

Krishnan et al (2011) conducted a phase 3 trial comparing tandem autologous HCT with tandem autologous HCT plus RIC allo-HCT (tandem auto-allo group) in patients from 37 transplant centers in the United States, who, between 2003 and 2007, had received an autologous HCT (N=710).<sup>42</sup> Of these patients, 625 had standard-risk disease, and 156 (83%) of 189 patients in the tandem auto-allo group and 366 (84%) of 436 in the tandem autologous group received a second transplant. Patients were eligible for transplantation if they were younger than 70 years of age and had completed at least 3 cycles of systemic therapy for myeloma within the past 10 months. Patients were assigned to a second autologous or allo-HCT based on the availability of an HLA-matched sibling donor. Patients in the tandem autologous group were subsequently randomized to observation (n=219) or maintenance therapy with thalidomide plus dexamethasone (n=217). Kaplan-Meier estimates of 3-year PFS were 43% (95% CI, 36% to 51%) in the tandem auto-allo group and 46% (95% CI, 42% to 51%) in the tandem autologous group (p=.67). The OS rates also did not differ at 3 years (77% [95% CI, 72% to 84%] vs. 80% [95% CI, 77% to 84%]; p=.19). Grade 3, 4, or 5 morbidity rates between the 2 groups were 46% and 42%, respectively. The data suggested nonmyeloablative tandem auto-allo HCT was no more effective than tandem autologous HCT for patients with standard-risk myeloma.

### **Retrospective Studies**

Maffini et al (2018) published long-term follow-up results for MM patients treated with tandem autologous-allogeneic HCT.<sup>43</sup> The study consisted of 209 patients (86%) who received tandem HCT upfront and 35 patients (14%) who received tandem HCT after failing a previous autologous HCT. Median follow-up was 8.3 years. Five-year OS and PFS were 54% (95% CI, 48% to 60%) and 31% (95% CI, 25% to 36%), respectively; 10-year OS and PFS were 41% (95% CI, 34% to 48%) and 19% (95% CI, 13% to 24%), respectively. Overall non-relapse mortality was 2% at 100 days and 14% at 5 years.

### **Subsection Summary: Tandem Autologous Hematopoietic Cell Transplantation Followed by Reduced-Intensity Conditioning and Allogeneic Hematopoietic Cell Transplantation**

Although the body of evidence has shown inconsistencies regarding OS and disease-free survival rates, some studies have shown a survival benefit with tandem autologous HCT followed by RIC allo-HCT, although at the cost of higher treatment-related mortality compared with conventional treatments.

### **Allogeneic Hematopoietic Cell Transplantation**

#### **Clinical Context and Therapy Purpose**

The purpose of allo-HCT as initial or salvage treatment in individuals who have newly diagnosed MM is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

#### ***Populations***

The relevant population of interest is individuals with newly diagnosed MM.

#### ***Interventions***

The therapy being considered is allo-HCT as initial or salvage treatment.

#### ***Comparators***

The following therapies are currently being used to make decisions about newly diagnosed MM: conventional chemotherapy with or without novel therapies.

#### ***Outcomes***

The general outcomes of interest are OS and treatment-related morbidity.

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

### Study Selection Criteria

Methodologically credible studies were selected using the following principles:

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

### Review of Evidence

#### Narrative Reviews

The role of allo-HCT remains controversial, in particular, because of conflicting data from cooperative group trials, but also because of improvement in outcomes with proteasome inhibitors, new immunomodulatory agents, and the use of posttransplant maintenance therapy. These issues were reviewed and summarized in 2013 and 2014.<sup>44,45</sup>

Although myeloablative allo-HCT may be the only curative treatment in MM (due to its graft-versus-myeloma effect), its use has been restricted to younger patients. Even with the limited indications, the toxicity-related death rate for infections and GVHD is high, and this strategy has been almost completely abandoned.<sup>46</sup>

In an approach to reduce non-relapse mortality associated with allo-HCT, RIC methods have been investigated. Most studies are phase 2, with no comparison with other treatment modalities. One retrospective study has compared myeloablative with nonmyeloablative conditioning.<sup>47</sup> This study, conducted by the EBMT, found that treatment-related mortality was significantly reduced with RIC but, because of a higher relapse or progression rate, there was no significant improvement in OS. When RIC allo-HCT 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 preclude relapses.<sup>48</sup> Therefore, RIC allogeneic transplantation is currently used after tumor mass reduction with high-dose chemotherapy and autologous HCT.<sup>46</sup>

#### Section Summary: Allogeneic Hematopoietic Cell Transplantation

Studies have reported on patients with both myeloablative conditioning and RIC. Limitations of the published evidence include patient sample heterogeneity, variability in treatment protocols, short follow-up periods, inconsistency in reporting important health outcomes, and inconsistency in reporting or collecting outcomes. Nonmyeloablative allo-HCT as first-line therapy is associated with lower transplant-related mortality but a greater risk of relapse; convincing evidence is lacking that allo-HCT improves survival better than autologous HCT.

### Relapsed or Refractory Multiple Myeloma Salvage Autologous Hematopoietic Cell Transplantation

#### Clinical Context and Therapy Purpose

The purpose of autologous HCT in individuals who have relapsed MM after failing an autologous HCT is to provide a treatment option that is an alternative to or an improvement on existing therapies. The following PICO was used to select literature to inform this review.

#### *Populations*

The relevant population of interest is individuals with relapsed MM after failing an autologous HCT.

#### *Interventions*

The therapy being considered is autologous HCT.

### ***Comparators***

The following therapies are currently being used to make decisions about relapsed MM: conventional chemotherapy with or without novel therapies. Despite improved survival rates with autologous HCT versus conventional chemotherapy, many patients will relapse and require salvage therapy.

Therapeutic options for patients with relapsed MM after a prior autologous HCT include regimens utilizing newer agents (e.g., daratumumab- and bortezomib-based regimens), regimens utilizing traditional chemotherapy, or a second HCT.<sup>15</sup>

### ***Outcomes***

The general outcomes of interest are OS and treatment-related morbidity.

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

### **Study Selection Criteria**

Methodologically credible studies were selected using the following principles:

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

### **Review of Evidence**

#### **Systematic Reviews**

A review by Ziogas et al (2017) included studies of autologous HCT as salvage therapy in patients whose MM has relapsed following an initial autologous HCT (either single or tandem).<sup>49</sup> The primary aim of the review was to summarize the circumstances in which a second autologous HCT should be administered, especially as more regimens show potential as salvage or reinduction therapy, including anti-CD38 antibodies, next-generation proteasome inhibitors, or immunomodulatory drugs. The authors noted that most studies have been retrospective, or of small patient samples; however, in 15 of the included studies, more than 40 patients were evaluated. Overall response rates ranged from 55.3% to 97.4%; following a salvage transplant, median PFS across studies varied considerably (range, 8.5 to 40 months). The questions examined in the review concerned the safety and efficacy of a second autologous HCT, predictors of outcome and best maintenance approach following salvage autologous HCT, and the future of the treatment. Based on general agreement from studies that showed the particular benefit of salvage autologous HCT in patients with longer intervals from the first transplant to initial relapse, reviewers recommended that the treatment is administered to patients with remission of greater than 18 months following initial autologous HCT.

Given heterogeneity across studies of novel maintenance therapies, reviewers called for more prospective studies, noting melphalan as a well-established basis for treatment.

In 2017, the EBMT reported on potential treatments for myeloma patients whose disease has relapsed following autologous stem cell transplantation; the included systematic review was primarily descriptive.<sup>50</sup> Among the treatments suggested were immunomodulatory drugs (i.e., thalidomide, lenalidomide, pomalidomide), proteasome inhibitors (i.e., bortezomib, carfilzomib, ixazomib), monoclonal antibodies, and autologous HCT or allo-HCT. Reviewers noted that most of the studies of autologous HCT and allo-HCT are retrospective analyses of case series or data drawn from databases; to confirm the apparent benefits of transplantation over chemotherapy alone, reviewers suggested that more prospective studies are needed for both types of procedure following relapse.

### Randomized Controlled Trials

Goldschmidt et al (2020) conducted a randomized, open-label, multicenter phase 3 study (the ReLApsE trial) in patients aged 18 to 75 years with a first to third relapse of MM.<sup>51</sup> These patients had previously undergone autologous HCT and attained remission of at least 12 months prior to relapse. Patients were randomized to receive a repeat autologous HCT (n=139) or continuous therapy with lenalidomide plus dexamethasone (n=138). Patients who underwent repeat autologous HCT also received reinduction therapy with lenalidomide plus dexamethasone, salvage high-dose chemotherapy with melphalan, and lenalidomide maintenance. In the primary ITT analysis, no significant differences were seen in PFS (median, 20.7 months vs. 18.8 months for transplant vs. control; HR, 0.87; 95% CI, 0.65 to 1.16; p=.34) or OS (median not reached in the transplant group vs. 62.7 months in the control arm; HR, 0.81; 95% CI, 0.52 to 1.28; p=.37). However, only 71% of patients assigned to the transplant group actually underwent salvage high-dose chemotherapy and autologous HCT. Post hoc analyses found that the patients who received salvage high-dose chemotherapy and autologous HCT had a trend toward superior PFS compared to the control group, and statistically superior OS (median not reached vs. 57 months; HR, 0.56; 95% CI, 0.32 to 0.99; p=.046).

Cook et al (2014) conducted a multicenter, randomized, open-label, phase 3 study involving 51 centers across the United Kingdom, with enrollment occurring between 2008 and 2012.<sup>52</sup> Inclusion criteria were patients at least 18 years and with MM who needed treatment for first progressive or relapsed disease at least 18 months after a previous autologous HCT. Before randomization, eligible patients received bortezomib, doxorubicin, and dexamethasone induction therapy and then underwent peripheral blood stem cell mobilization and harvesting, if applicable. Eligible patients were randomized (1:1) to high-dose melphalan 200 mg/m<sup>2</sup> plus salvage autologous HCT or to oral cyclophosphamide 400 mg/m<sup>2</sup>/wk for 12 weeks. The primary endpoint was time to disease progression, analyzed by ITT. A total of 297 patients were enrolled, of whom 293 received induction therapy. Among the latter, 174 patients with sufficient harvest of peripheral blood stem cells were randomized to salvage HCT (n=89) or cyclophosphamide (n=85). After a median follow-up of 31 months, median time to progression was significantly longer in the salvage HCT group (19 months; 95% CI, 16 to 25 months) than in the cyclophosphamide group (11 months; 95% CI, 9 to 12 months; HR, 0.36; 95% CI, 0.25 to 0.53; p<.001). Frequently reported (>10% of patients) grade 3 or 4 adverse events with induction, salvage HCT, and cyclophosphamide were: neutropenia (43% [125/293] patients receiving induction vs. 76% [63/83] patients receiving salvage HCT vs. 13% [11/84] patients receiving cyclophosphamide), thrombocytopenia (51% [150/293] after induction vs. 72% [60/83] with salvage HCT vs. 5% [4/84] with cyclophosphamide), and peripheral neuropathy (12% [35/293] after induction vs. none with salvage HCT or cyclophosphamide).

Final survival data for this trial were reported in 2016.<sup>53</sup> The HCT group had a superior median OS (67 months; 95% CI, 55 months to not estimable) compared with the chemotherapy group (52 months; 95% CI, 42 to 60 months; p<.001). Time to disease progression continued to favor the HCT group at the longer follow-up (19 months [95% CI, 16 to 26 months] vs. 11 months [95% CI, 9 to 12 months]; p=.02). There were no further adverse events related to the HCT procedure reported during longer follow-up. The cumulative incidence of second malignancies was 5.2% (95% CI, 2.1% to 8.2%).

### Retrospective Studies

A retrospective study by Ikeda et al (2019) examined outcomes of a second HCT (either allo-HCT [n=192] or repeat autologous HCT [n=334]) in patients with relapsed or progressive MM after a first autologous HCT.<sup>54</sup> Rates of 5-year OS were 23.8% after allo-HCT and 33.7% after repeat autologous HCT; however, differences in these rates were likely influenced by differences in baseline characteristics, such as age, performance status, time from initial HCT, and response to chemotherapy before HCT. Patients were assigned risk categories based on response to reinduction, performance status, and time from initial HCT; in intermediate-risk patients (the largest risk subgroup), OS rates were higher with repeat autologous HCT versus allo-HCT (28.2% vs. 21.5%; p<.004). No significant differences were noted in the low- and high-risk subgroups.



A multicenter retrospective study by Michaelis et al (2013) evaluated 187 patients drawn from the Center for International Blood and Marrow Transplantation who were treated with a second autologous HCT following relapse or progression of MM.<sup>55</sup> All but 12% of patients received a second autologous HCT, 12 months or more after the initial transplantation; prior to a second autologous HCT, only 40% (n=74) of patients were in complete or partial response. In patients whose time from the first transplant to the first relapse was greater than 36 months, investigators noted a decrease in the risk of relapse after a second autologous HCT (relative risk, 0.63; 95% CI, 0.49 to 0.97), and an increase in PFS and OS. For such individuals, the 3-year PFS rate was twice that of the cohort at large (26% vs. 13%), and 5-year PFS rate (13%) was considerably superior to that of the larger group (5%). A comparison of OS rates showed a similar improvement: while the 5-year OS rate of 29% for the entire cohort was comparable to other studies of a second autologous HCT in relapsed MM, the 5-year OS rate for individuals with a time-to-relapse of 36 months or greater was considerably improved (48%; p=.026). After 3 years, only 4% (95% CI, 2% to 8%) of patients experienced non-relapse mortality; however, relapse or disease progression was observed in 82% of patients after 3 years (vs. 68% of patients with time-to-relapse  $\geq$ 36 months after initial transplant). The investigators acknowledged a lack of data on maintenance regimens, cytogenetics, or staging of individual disease; they also noted that, during the observed time frame (1995 to 2008), several newer therapies were introduced, which were not accounted for during analysis. However, given findings similar to other retrospective studies during the same period, the investigators concluded that a second autologous HCT is an appropriate salvage therapy for eligible patients.

Qazilbash et al (2006) reported their experience with salvage autologous HCT or allo-HCT after a failed first autologous transplant.<sup>56</sup> Fourteen patients (median age, 52 years) received a second autologous transplant and 26 patients (median age, 51 years) underwent a RIC allo-HCT. The median interval between first and second transplants was 25 months for the autologous group and 17 months for the allogeneic group. After a median follow-up of 18 months (range, 2 to 69 months) for the autologous group, median PFS was 6.8 months, and OS was 29 months. After a median follow-up of 30 months (range, 13 to 66 months) for the allogeneic group, median PFS was 7.3 months, and OS was 13 months. Univariate analysis in the allogeneic group found that an interval of more than 1 year between the first and salvage transplants predicted a significantly better OS (p=.02). None of the prognostic factors evaluated for the allogeneic group had a significant impact on survival in the autologous group (e.g., age, cytogenetics, type of donor, chronic GVHD).

### **Section Summary: Salvage Autologous Hematopoietic Cell Transplantation**

Despite some limitations of the published evidence, including patient sample heterogeneity, variability in treatment protocols, and short follow-up periods, the available trial evidence has suggested OS rates are improved with autologous HCT compared with conventional chemotherapy or continuous lenalidomide plus dexamethasone in this setting.

### **Tandem Autologous Hematopoietic Cell Transplantation for Relapse After First Autologous Hematopoietic Cell Transplantation**

#### **Clinical Context and Therapy Purpose**

The purpose of tandem autologous HCT in individuals who have refractory MM after failing a first HCT is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

#### ***Populations***

The relevant population of interest is individuals with refractory MM after failing a first HCT.

#### ***Interventions***

The therapy being considered is tandem autologous HCT.

### **Comparators**

The following therapies are currently being used to make decisions about refractory MM: conventional chemotherapy with or without novel therapies.

### **Outcomes**

The general outcomes of interest are OS and treatment-related morbidity.

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

### **Study Selection Criteria**

Methodologically credible studies were selected using the following principles:

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

### **Review of Evidence**

#### **Systematic reviews**

A 2003 evidence-based systematic review sponsored by the American Society for Blood and Marrow Transplantation summarized data from 4 relevant clinical series.<sup>57</sup> Reviewers 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 found to increase the likelihood of durable remissions and extend survival included a chemosensitive relapse, younger age, long disease-free or progression-free interval since the initial autotransplant, and fewer chemotherapy regimens before the initial autotransplant.

A review by McCarthy and Holstein (2016) summarized current treatment regimens for patients with myeloma who are eligible for autologous HCT or allo-HCT.<sup>58</sup> Following discussion of studies on induction, salvage, consolidation, and maintenance therapies, reviewers offered recommendations based on the available evidence. Based on 4 studies comparing autologous HCT with chemotherapy alone, reviewers recommended autologous HCT as standard of care for patients who are eligible; additionally, they recommended autologous HCT for the first relapse, based on the pooled HR of 2 studies showing a benefit in patients given autologous HCT following relapse (HR, 0.57;  $p=.037$ ).

Reviewers noted the increasing uncertainty regarding the efficacy and safety of allo-HCT compared with novel therapies; studies directly comparing allo-HCT with autologous HCT lack consistent results. However, RIC allo-HCT has been shown to have some benefit for patients whose disease is high-risk, especially in younger populations. As maintenance therapy, reviewers considered a number of studies evaluating thalidomide ( $n=8$ ), which had conflicting results, as well as 3 randomized studies of lenalidomide, concluding that the latter treatment is standard of care.

#### **Retrospective Studies**

Olin et al (2009) reported their experience with 41 patients with MM who received a second salvage autologous HCT for relapsed disease.<sup>59</sup> The median time between transplants was 37 months (range, 3 to 91 months). The overall response rate in assessable patients was 55%. Treatment-related mortality was 7%. Median follow-up was 15 months, with a median PFS of 8.5 months and median OS of 20.7 months. In a multivariate analysis of OS, the number of prior lines of therapy ( $\geq 5$ ) and time to progression after initial transplant were the strongest predictors of OS.

### **Section Summary: Tandem Autologous Hematopoietic Cell Transplantation for Relapse after First Autologous Hematopoietic Cell Transplantation**

The evidence has shown tandem autologous HCT improves OS rates in this setting.

### **Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal gammopathy, and Skin abnormalities (POEMS) Syndrome**

#### **Clinical Context and Therapy Purpose**

The purpose of HCT in individuals who have POEMS syndrome is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

#### ***Populations***

The relevant population of interest is individuals with POEMS syndrome.

#### ***Interventions***

The therapy being considered is HCT.

#### ***Comparators***

The following therapies are currently being used to make decisions about POEMS syndrome: conventional chemotherapy with or without novel therapies.

#### ***Outcomes***

The general outcomes of interest are OS and treatment-related morbidity.

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

#### **Study Selection Criteria**

Methodologically credible studies were selected using the following principles:

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

#### **Review of Evidence**

##### **Systematic Reviews**

A 2012 Cochrane review has provided a comprehensive source on the treatment of POEMS syndrome.<sup>60</sup> Reviewers performed a broad literature search and identified no RCTs, no quasi-RCTs, no historically controlled trials, and no trials with concurrent controls that met selection criteria.

Reviewers selected 6 small series (N=57 patients) evaluating autologous HCT. Two-year survival rates ranged from 94% to 100%. Pooled results suggested that treatment-related mortality with autologous HCT would be 3 (2.7%) of 112. Reviewers cautioned that long-term outcomes with autologous HCT have not been evaluated and require continuing study.

A second 2012 review article found that case series suggested most patients achieve at least some neurologic and functional improvement using conditioning doses of melphalan ranging from 140 to 200 mg/m<sup>2</sup>.<sup>6</sup> Responses have been reported as durable, but relapse occurs. Symptomatic progression has typically been reported as rare, with most progressions identified as rising vascular endothelial growth factor and radiographic. The reviewer also reported that long-term outcomes

with autologous HCT are unclear given the sparse numbers. Findings were similar in an updated 2019 review by the same author.<sup>9</sup>

A review article by Autore et al (2017) evaluated potential mobilizing regimens for the collection of peripheral blood in patients with POEMS syndrome; reviewers also included a number of small studies evaluating the roles of vascular endothelial growth factor and lenalidomide in cases of POEMS syndrome.<sup>61</sup> In 7 studies using high-dose melphalan followed by autologous HCT, clinical response rates ranged from 69.3% to 100%, and morbidity rates related to autologous HCT ranged from 21.7% to 42.9%. Four studies evaluating lenalidomide as a treatment of POEMS syndrome showed clinical response rates ranging from 78% to 100%, although the case series included were small. Reviewers reported mixed results on the use of granulocyte colony-stimulating factor with chemo-mobilization compared with granulocyte colony-stimulating factor alone in 11 case series, in which engraftment syndrome occurred in 11% to 37.5% of patients when reported.

### Retrospective Studies

In a retrospective, multicenter study, Cook et al (2017) evaluated 127 patients with POEMS syndrome who had received high-dose therapy (melphalan) and autologous HCT as first-line therapy; outcomes included transplant results, organ-specific response, OS, and PFS, and non-relapse mortality.<sup>62</sup> Engraftment was successful in most patients (96.8%); engraftment syndrome (n=29; 23%) did not appear significantly associated either with previous treatment ( $p<.018$ ) or the inclusion of cyclophosphamide as a mobilizer ( $p=.590$ ). Following transplantation, 48% of patients had achieved hematologic CR (n=49), 16 of whom were in a lower status preceding autologous HCT. At the 3-year follow-up, the likelihood of relapse was 12% (95% CI, 5% to 18%); after 5 years, the likelihood of PFS was 74% (95% CI, 63.2% to 83.7%). Rates of non-relapse mortality and OS after 5 years were also favorable: respectively, 7.7% (95% CI, 1.9% to 13.6%) and 88.6% (95% CI, 81.5% to 95.8%). The authors noted a significant association between a patient's performance score and PFS ( $p=.032$ ), recommending that caregivers consider administering therapy before transplant to improve the performance score. A limitation of the study was that, although patients were treated between 1994 and 2010, newer imaging techniques were not reported, nor were vascular endothelial growth factor serum levels accounted for in the analysis.

### Case Series

A single-center series published in 2012 reported a 5-year OS rate of 94% and a PFS rate of 75% among 59 patients entered between 1999 and late 2011.<sup>63</sup> A second series (2014) included 9 patients with advanced POEMS syndrome who had Eastern Cooperative Oncology Group Performance Status scores of 3 or 4 and were treated with high-dose melphalan therapy followed by autologous HCT from 2004 to 2011.<sup>64</sup> Eight patients achieved an initial hematologic response, 4 of whom had CRs. At a median follow-up of 44 months (range, 8 to 94 months), 7 patients were alive, with a 3-year OS rate of 78%. There were no hematologic relapses in the survivors. One patient died of disease progression; the other died of pneumonia. All survivors improved in general performance status and clinical response. More recent single-center series publications including 36 to 95 patients show a 5-year overall survival rate approximating 90%.

### Section Summary: POEMS Syndrome

There is a lack of RCT evidence on the use of HCT for POEMS syndrome, but cohort studies and case series have reported improvements in symptoms and disease progression after HCT. POEMS syndrome is rare, and treatment options are few. Also, the natural history of POEMS does not suggest that spontaneous improvement will occur in the absence of treatment.

### Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

### **Clinical Input from Physician Specialty Societies and Academic Medical Centers**

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.

#### **2017 Input**

In response to requests, input was received from 1 specialty medical society, 1 academic medical center, and 2 Blue Distinction Centers for Transplant while this policy was under review in 2017. There was a consensus that allogeneic hematopoietic cell transplantation (HCT) is investigational for newly diagnosed multiple myeloma (MM) and as salvage therapy after primary graft failure and for the primary progressive disease.

#### **2013 Input**

In response to requests, input was received from 3 academic medical centers and 6 Blue Distinction Centers for Transplant while this policy was under review in 2013. There was near-consensus that autologous HCT is medically necessary for POEMS syndrome and near-consensus that allogeneic and tandem HCT are investigational for POEMS syndrome.

### **Practice Guidelines and Position Statements**

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

#### **American Society of Clinical Oncology**

In 2019, the American Society of Clinical Oncology (ASCO) published practice guidelines for the treatment of MM.<sup>65</sup> The guidelines recommend offering up-front transplant to all eligible patients, although delayed HCT may be considered in select patients. Salvage or delayed HCT may be used as consolidation at first relapse in patients who choose not to proceed with HCT initially. Tandem autologous HCT and allogeneic HCT (allo-HCT) should not be routinely recommended. However, up-front tandem autologous HCT can be considered for select high-risk patients or those with a suboptimal response to the initial transplant; allo-HCT may be considered in select high-risk patients in the context of a clinical trial. For relapsed MM, autologous HCT, if not received after primary induction therapy, should be offered to transplant-eligible patients. Repeat HCT may be considered in relapsed MM if progression-free survival after the first transplant was 18 months or greater.

#### **American Society for Transplantation and Cellular Therapy**

In 2015, the American Society for Blood and Marrow Transplantation (ASBMT; now referred to as the American Society for Transplantation and Cellular Therapy [ASTCT]) published evidence-based guidelines on the use of HCT in patients with MM.<sup>66</sup> The ASBMT recognized that much of the evidence from randomized controlled trials (RCTs) summarized in the 2015 guidelines came from trials that predated the novel triple-therapy induction regimens. Furthermore, advances in supportive care and earlier disease detection have increasingly influenced decision making and allow individual tailoring of therapy. The ASBMT guidelines did not address POEMS or other plasma cell dyscrasias besides MM. T

The ASTCT updated guidance for transplantation and cellular therapies in MM in 2022.<sup>67</sup> The panel endorsed continued use of autologous HCT for patients with newly diagnosed MM as a standard-of-care option and did not recommend front-line use of allo-HCT and CAR-T outside the setting of a clinical trial. For patients not undergoing autologous HCT upfront, the panel recommended its use in first relapse. The panel also encouraged allo-HCT in relapsed/refractory MM setting only in the context of clinical trial.

The ASBMT and 3 other groups (2015) published joint guidelines based on an expert consensus conference.<sup>68</sup> These guidelines contained the following recommendations for HCT as salvage therapy:

"...autologous HCT: (1) In transplantation-eligible patients relapsing after primary therapy that did NOT include an autologous HCT, high-dose therapy with HCT as part of salvage therapy should be considered standard; (2) High-dose therapy and autologous HCT should be considered appropriate therapy for any patients relapsing after primary therapy that includes an autologous HCT with initial remission duration of more than 18 months; (3) High-dose therapy and autologous HCT can be used as bridging strategy to allogeneic HCT; (4) The role of postsalvage HCT maintenance needs to be explored in the context of well-designed prospective trials that should include new agents, such as monoclonal antibodies, -modulating agents, and oral proteasome inhibitors; (5) Autologous HCT consolidation should be explored as a strategy to develop novel conditioning regimens or post-HCT strategies in patients with short remission (less than 18 months remissions) after primary therapy; and (6) Prospective randomized trials need to be performed to define the role of salvage autologous HCT in patients with MM [multiple myeloma] relapsing after primary therapy comparing to 'best non-HCT' therapy.

Regarding allogeneic HCT... (1) Allogeneic HCT should be considered appropriate therapy for any eligible patient with early relapse (less than 24 months) after primary therapy that included an autologous HCT and/or with high-risk features (i.e., cytogenetics, extramedullary disease, plasma cell leukemia, or high lactate dehydrogenase); (2) Allogeneic HCT should be performed in the context of a clinical trial if possible; (3) The role of post allogeneic HCT maintenance therapy needs to be explored in the context of well-designed prospective trials; and (4) Prospective randomized trials need to be performed to define the role of salvage allogeneic HCT in patients with MM relapsing after primary therapy."

In 2020, the ASTCT published a guideline on indications for HCT and immune effector cell therapy.<sup>69</sup>

Regarding plasma cell dyscrasias, the guideline states that MM remains the most common indication for autologous HCT. For rarer plasma cell dyscrasias like POEMS syndrome, autologous HCT may be considered a clinical option on the basis of single-center and registry data. Detailed recommendations in adults can be found in Table 2.

**Table 2. Summary of Recommendations for Hematopoietic Cell Transplantation in Plasma Cell Disorders Including Multiple Myeloma and POEMS Syndrome**

Indication	Allogeneic HCT	Autologous HCT
Myeloma, initial response	D	S
Myeloma, sensitive relapse	S	S
Myeloma, refractory	C	C
POEMS syndrome	N	C
Relapse after autologous transplant	C	C

C: standard of care, clinical evidence available; D: developmental; HCT: hematopoietic cell transplantation; N: not generally recommended; S: standard of care

### International Myeloma Working Group

The 2010 conclusions and recommendations of the International Myeloma Working Group consensus statement on the current status of allo-HCT for MM are as follows: myeloablative allo-HCT may cure a minority of patients but is associated with high transplant-related mortality, but could be evaluated in well-designed prospective clinical trials.<sup>70</sup> Nonmyeloablative allo-HCT as first-line therapy is associated with lower transplant-related mortality but a greater risk of relapse and convincing evidence is lacking that allo-HCT improves survival compared with autologous HCT.

### **National Comprehensive Cancer Network**

#### **Autologous Hematopoietic Cell Transplantation**

The National Comprehensive Cancer Network (NCCN) guideline for multiple myeloma (v.2.2024 ) states that autologous HCT is the preferred option after induction therapy in transplant-eligible patients, but a delayed HCT after early stem cell collection and storage is appropriate as well (category 1 recommendation).<sup>4</sup> A repeat HCT can be considered for refractory/progressive disease after primary treatment in patients with prolonged response to initial HCT.

#### **Tandem Hematopoietic Cell Transplantation**

The NCCN guideline for multiple myeloma (v.2.2024 ) recommends collecting enough stem cells for 2 transplants in younger patients if tandem transplant or salvage transplant would be considered.<sup>4</sup> A tandem transplant with or without maintenance therapy can be considered for all patients who are candidates for HCT and is an option for patients who do not achieve at least a very good partial response after the first autologous HCT and those with high-risk features.

#### **Allogeneic Hematopoietic Cell Transplantation**

The NCCN guideline for multiple myeloma (v.2.2024 ) states the following for allo-HCT: "Allogeneic HCT includes either myeloablative or nonmyeloablative (i.e., "mini" transplant) transplants. Allogeneic HCT has been investigated as an alternative to autologous HCT to avoid the contamination of reinfused autologous tumor cells, but also to take advantage of the beneficial graft-versus-tumor effect associated with allogeneic transplants. However, lack of a suitable donor and increased morbidity has limited this approach, particularly for the typical older MM population".<sup>4</sup>

#### **Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal gammopathy, and Skin abnormalities (POEMS) Syndrome**

The NCCN guideline for multiple myeloma (v.2.2024 ) recommends autologous HCT in patients with POEMS syndrome who are eligible as sole therapy or as consolidation therapy after induction therapy.<sup>4</sup>

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

Not applicable.

#### **Medicare National Coverage**

Medicare has the following national coverage determination for the use of HCT for MM.<sup>71</sup> "Effective ... January ... 2016, allogeneic HSCT [hematopoietic stem cell transplantation] for multiple myeloma is covered by Medicare only for beneficiaries with Durie-Salmon Stage II or III multiple myeloma, or International Staging System (ISS) Stage II or Stage III multiple myeloma and participating in an approved prospective clinical study that meets the criteria below. There must be appropriate statistical techniques to control for selection bias and confounding by age, duration of diagnosis, disease classification, International Myeloma Working Group (IMWG) classification, ISS stage, comorbid conditions, type of preparative/conditioning regimen, graft vs. host disease (GVHD) prophylaxis, donor type and cell source.

A prospective clinical study seeking Medicare coverage for allogeneic HSCT for multiple myeloma pursuant to CED must address the following question:

Compared to patients who do not receive allogeneic HSCT, do Medicare beneficiaries with multiple myeloma who receive allogeneic HSCT have improved outcomes as indicated by:

- GVHD (acute and chronic);
- Other transplant-related adverse events;
- Overall survival; and
- (optional) Quality of life?"

### Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 3.

**Table 3. Summary of Key Trials**

NCT No.	Trial Name	Planned Enrollment	Completion Date
<i>Ongoing</i>			
NCT01208662 <sup>a</sup>	A Randomized Phase III Study Comparing Conventional Dose Treatment Using a Combination of Lenalidomide, Bortezomib, and Dexamethasone (RVD) to High-dose Treatment With Peripheral Stem Cell Transplant in the Initial Management of Myeloma in Patients up to 65 Years of Age	660	Sep 2025
NCT05675319	Allogeneic Stem Cell Transplantation vs. Conventional Therapy as Salvage Therapy for Relapsed / Progressive Patients With Multiple Myeloma After First-line Therapy	482	Mar 2033
<i>Unpublished</i>			
NCT02322320	Continued, Long-Term Follow-Up and Lenalidomide Maintenance Therapy for Patients on BMT CTN 0702 (BMT CTN #Q07LT)	273 (actual enrollment)	Jun 2019 (Completed)

NCT: national clinical trial.

<sup>a</sup> Denotes industry-sponsored or cosponsored trial.

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## Documentation for Clinical Review

### Please provide the following documentation:

- Referring provider history and physical
- Bone marrow transplant consultation report and/or progress notes documenting:
  - Diagnosis (including disease staging) and prognosis
  - Synopsis of alternative treatments performed and results
  - Specific transplant type being requested
- Surgical consultation report and/or progress notes
- Results of completed transplant evaluation including:
  - Clinical history including comorbidities
  - Specific issues identified during the transplant evaluation
  - Consultation reports/letters (when applicable)
  - Correspondence from referring provider (when applicable)
  - Identification of donor for allogeneic related bone marrow/stem cell transplant (when information available)
- Medical social service/social worker and/or psychiatric (if issues are noted) evaluations including psychosocial assessment or impression of patient's ability to be an adequate candidate for transplant
- Radiology reports including:
  - Chest x-ray (CXR)
  - PET scan, CT scan and bone survey (as appropriate)
- Cardiology procedures and pulmonary function reports:
  - EKG
  - Echocardiogram
  - Pulmonary function tests (PFTs)
- Biopsy/Pathology reports including:
  - Bone marrow biopsy
  - Lymph node biopsy (as appropriate)
- Laboratory reports

## Coding

*This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.*

*The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.*

Type	Code	Description
CPT®	38204	Management of recipient hematopoietic progenitor cell donor search and cell acquisition
	38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic
	38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous
	38207	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage
	38208	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor
	38209	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor
	38210	Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion
	38211	Transplant preparation of hematopoietic progenitor cells; tumor cell depletion
	38212	Transplant preparation of hematopoietic progenitor cells; red blood cell removal
	38213	Transplant preparation of hematopoietic progenitor cells; platelet depletion
	38214	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion
	38215	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer
	38230	Bone marrow harvesting for transplantation; allogeneic
	38232	Bone marrow harvesting for transplantation; autologous
	38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor
	38241	Hematopoietic progenitor cell (HPC); autologous transplantation
HCPCS	S2140	Cord blood harvesting for transplantation, allogeneic
	S2142	Cord blood-derived stem-cell transplantation, allogeneic
	S2150	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 post-transplant care in the global definition

## Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
01/07/2011	BCBSA Medical Policy adoption
03/28/2014	Policy title change from Hematopoietic Stem-Cell Transplantation for Multiple Myeloma with position change
03/30/2015	Policy revision without position change
03/01/2017	Policy title change from Hematopoietic Stem-Cell Transplantation for PlasmaCell Dyscrasias, Including Multiple Myeloma and POEMS Syndrome Policy revision without position change
01/01/2018	Coding update
03/01/2018	Policy revision without position change
03/01/2019	Policy revision without position change
11/01/2019	Policy revision without position change
04/01/2020	Annual review. No change to policy statement. Literature review updated.
03/01/2021	Annual review. Policy statement and literature updated.
04/01/2022	Annual review. No change to policy statement. Literature review updated.
10/01/2022	Administrative update.
04/01/2023	Annual review. Policy statement and literature review updated
04/01/2024	Annual review. No change to policy statement. Policy guidelines and literature review updated.

## Definitions of Decision Determinations

**Medically Necessary:** Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) 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 the Member's illness, injury, or disease.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

### Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at [www.blueshieldca.com/provider](http://www.blueshieldca.com/provider).

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: [MedPolicy@blueshieldca.com](mailto:MedPolicy@blueshieldca.com)

*Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.*

## Appendix A

## POLICY STATEMENT

(No changes)

## BEFORE

Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias,  
Including Multiple Myeloma and POEMS Syndrome 8.01.17

## Policy Statement:

## Multiple Myeloma

- I. A single or second (salvage) autologous hematopoietic cell transplantation may be considered **medically necessary** to treat multiple myeloma.
- II. Tandem autologous hematopoietic cell transplantation may be considered **medically necessary** to treat multiple myeloma in individuals 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 section.)
- III. Tandem transplantation with an initial round of autologous hematopoietic cell transplantation followed by a non-marrow-ablative conditioning regimen and allogeneic hematopoietic stem cell transplantation (i.e., reduced-intensity conditioning transplant) may be considered **medically necessary** to treat newly diagnosed multiple myeloma individuals.
- IV. Allogeneic hematopoietic cell transplantation, myeloablative or nonmyeloablative, as initial therapy of newly diagnosed multiple myeloma or as salvage therapy, is considered **investigational**.

## POEMS Syndrome

- V. Autologous hematopoietic cell transplantation may be considered **medically necessary** to treat disseminated POEMS syndrome (see Policy Guidelines section).

## AFTER

Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias,  
Including Multiple Myeloma and POEMS Syndrome 8.01.17

## Policy Statement:

## Multiple Myeloma

- I. A single or second (salvage) autologous hematopoietic cell transplantation may be considered **medically necessary** to treat multiple myeloma.
- II. Tandem autologous hematopoietic cell transplantation may be considered **medically necessary** to treat multiple myeloma in individuals 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 section.)
- III. Tandem transplantation with an initial round of autologous hematopoietic cell transplantation followed by a non-marrow-ablative conditioning regimen and allogeneic hematopoietic stem cell transplantation (i.e., reduced-intensity conditioning transplant) may be considered **medically necessary** to treat newly diagnosed multiple myeloma individuals.
- IV. Allogeneic hematopoietic cell transplantation, myeloablative or nonmyeloablative, as initial therapy of newly diagnosed multiple myeloma or as salvage therapy, is considered **investigational**.

## POEMS Syndrome

- V. Autologous hematopoietic cell transplantation may be considered **medically necessary** to treat disseminated POEMS syndrome (see Policy Guidelines section).



POLICY STATEMENT (No changes)	
BEFORE	AFTER
VI. Allogeneic and tandem hematopoietic cell transplantation are considered <b>investigational</b> to treat POEMS syndrome.	VI. Allogeneic and tandem hematopoietic cell transplantation are considered <b>investigational</b> to treat POEMS syndrome.