Policy Statement

Autologous or allogeneic hematopoietic cell transplantation is considered investigational as a treatment of autoimmune diseases, including, but not limited to, the following:

- Multiple Sclerosis
- Systemic Lupus Erythematosus
- Juvenile Idiopathic or Rheumatoid Arthritis
- Chronic Inflammatory Demyelinating Polyneuropathy
- Type 1 Diabetes

Autologous hematopoietic cell transplantation may be considered medically necessary as a treatment of systemic sclerosis/scleroderma if all of the following conditions are met:

- Adult patients younger than 60 years of age
- Maximum duration of condition of 5 years
- Modified Rodnan Scale Scores greater than or equal to 15
- Internal organ involvement as noted in the Policy Guidelines
- History of less than 6 months treatment with cyclophosphamide
- No active gastric antral vascular ectasia
- Do not have any exclusion criteria as noted in the Policy Guidelines

Autologous hematopoietic cell transplantation as a treatment of systemic sclerosis/scleroderma not meeting the above criteria is considered investigational.

The transplantation of Hepatitis C Virus (HCV)-viremic solid organs (kidney, lung, heart, liver, small bowel, pancreas) to a HCV non-viremic recipient with a plan to use direct-acting antiviral treatment for HCV is considered investigational.

Policy Guidelines

The American Society of Transplantation Consensus Conference on the use of hepatitis C viremic donors in solid organ transplantation concluded that the transplantation of organs from HCV viremic donors into HCV-negative recipients should be conducted only under monitored IRB-approved protocols and studies. (See Supplemental Information).

In 2003, CPT centralized codes describing allogeneic and autologous hematopoietic cell transplant services to the hematology section (CPT 38204-38242). Not all codes are applicable for each transplant procedure. For example, Plans should determine whether cryopreservation is performed. A range of codes describe services associated with cryopreservation, storage, and thawing of cells (38208-38215).

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

Types of cells 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
Hematopoietic Cell Transplantation for Autoimmune Diseases

- **38213**: Transplant preparation of hematopoietic progenitor cells; platelet depletion
- **38214**: Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion

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

Autologous HCT should be considered for patients with systemic sclerosis (SSc) only if the condition is rapidly progressing and the prognosis for survival is poor. An important factor influencing the occurrence of treatment-related adverse effects and response to treatment is the level of internal organ involvement. If organ involvement is severe and irreversible, HCT is not recommended. Below are clinical measurements which can be used to guide the determination of organ involvement.

Patients with internal organ involvement indicated by the following measurements may be considered for autologous HCT:
- Cardiac: abnormal electrocardiogram
- Pulmonary: diffusing capacity of carbon monoxide (DLCo) less than 80% of predicted value; decline of forced vital capacity (FVC) of greater than or equal to 10% in last 12 months; pulmonary fibrosis; ground glass appearance on high resolution chest CT
- Renal: scleroderma-related renal disease

Patients with internal organ involvement indicated by the following measurements should not be considered for autologous HCT:
- Cardiac: left ventricular ejection fraction less than 50%; tricuspid annular plane systolic excursion less than 1.8 cm; pulmonary artery systolic pressure more than 40 mm Hg; mean pulmonary artery pressure more than 25 mm Hg
- Pulmonary: DLCo less than 40% of predicted value; FVC less than 45% of predicted value
- Renal: creatinine clearance less than 40 ml/minute

**Description**

Most patients with autoimmune disorders respond to conventional drug therapies; however, conventional drug therapies are not curative—and a proportion of patients suffer from autoimmune diseases that range from the severe to the recalcitrant to the rapidly progressive. It is in this group of patients with severe autoimmune disease that alternative therapies have been sought, including hematopoietic cell transplantation (HCT).

**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]) prohibits 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

Autoimmune Diseases

Autoimmune diseases represent a heterogeneous group of immune-mediated disorders, including multiple sclerosis, systemic sclerosis/scleroderma, systemic lupus erythematosus, rheumatoid arthritis, and chronic immune demyelinating polyneuropathy. The National Institutes of Health has estimated that 5% to 8% of Americans have an autoimmune disorder.

The pathogenesis of autoimmune diseases is not well understood, but it appears to involve underlying genetic susceptibility and environmental factors that lead to loss of self-tolerance, culminating in tissue damage by the patient’s own immune system (T-cells).

Treatment

Immune suppression is a common treatment strategy for many of these diseases, particularly the rheumatic diseases (e.g., rheumatoid arthritis, systemic lupus erythematosus, scleroderma). Most patients with autoimmune disorders respond to conventional therapies, which consist of anti-inflammatory agents, immunosuppressants, and immunomodulating drugs; however, conventional drug therapies are not curative, and a proportion of patients suffer from autoimmune diseases that range from severe torecalcitrant to rapidly progressive. It is for this group of patients with severe autoimmune disease that alternative therapies have been sought, including hematopoietic cell transplantation (HCT). The primary concept underlying the use of HCT for these diseases is this: ablating and “resetting” the immune system can alter the disease process by inducing a sustained remission that possibly leads to cure.1

Hematopoietic Cell Transplantation

HCT is a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone-marrow-toxic doses of drugs with or without whole body radiotherapy. Hematopoietic stem cells may be obtained from the transplant recipient (autologous HCT) or a donor (allogeneic HCT). They can be harvested from bone marrow, peripheral blood, or umbilical cord blood shortly after delivery of neonates. Although cord blood is an allogeneic source, the stem cells in it are considered antigenically “naive” and thus are associated with a lower incidence of rejection or graft-versus-host disease. Cord blood is discussed in detail in Blue Shield of California Medical Policy: Placental and Umbilical Cord Blood as a Source of Stem Cells.

Immunologic compatibility between infused hematopoietic stem cells and the recipient is not an issue in autologous HCT. However, immunologic compatibility between donor and patient is critical for achieving a good outcome with allogeneic HCT. Compatibility is established by typing of human leukocyte antigens (HLAs) using cellular, serologic, or molecular techniques. HLA refers to the tissue type expressed at the HLA-A, -B, and -DR loci on each arm of chromosome 6. Depending on the disease being treated, an acceptable donor will match the patient at all or most of the HLA loci (with the exception of umbilical cord blood).

Autologous HCT

The goal of autologous HCT in patients with autoimmune diseases is to eliminate self-reactive lymphocytes (lymphoablation) and generate new, self-tolerant lymphocytes.2 This approach is in contrast to destroying the entire hematopoietic bone marrow (myeloablation), as is often
performed in autologous HCT for hematologic malignancies. Both lymphoablative and myeloablative regimens are used in patients with an autoimmune disease; however, there is no standard conditioning regimen. The efficacy of the different conditioning regimens has not been compared in clinical trials.

Currently, for autoimmune diseases, autologous transplant is preferred over allogeneic, in part because of the lower toxicity of autotransplant relative to allogeneic, the graft-versus-host disease associated with the allogeneic transplant, and the need to administer posttransplant immunosuppression after an allogeneic transplant.

Allogeneic HCT
Experience of using allogeneic HCT for autoimmune diseases is currently limited, but has two potential advantages over autologous transplant. First, the use of donor cells from a genetically different individual could possibly eliminate genetic susceptibility to the autoimmune disease and potentially result in a cure. Second, there exists a possible graft-versus-autoimmune effect, in which the donor T-cells attack the transplant recipient’s autoreactive immune cells.

Literature Review
Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life (QOL), and ability to function - including benefits and harms. Every clinical condition has specific outcomes that are important to patients and 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 technology, two domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent one 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. RCTs 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.

Hematopoietic Cell Transplantation for Autoimmune Diseases
Clinical Context and Therapy Purpose
The purpose of HCT in patients who have autoimmune diseases is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of HCT improve net health outcomes in patients with autoimmune diseases compared to conventional medication therapy?

The following PICOTS were used to select literature to inform this review.

Patients
The relevant population of interest are patients with autoimmune diseases, specifically:
- multiple sclerosis
- systemic sclerosis/scleroderma
- systemic lupus erythematosus
• juvenile idiopathic or rheumatoid arthritis
• chronic inflammatory demyelinating polyneuropathy
• type 1 diabetes
• other autoimmune diseases such as Crohn’s disease, immune cytopenias, and relapsing polychondritis.

Interventions
The therapy being considered is HCT. HCT is a procedure in which hematopoietic stem cells are infused to restore bone marrow function. Hematopoietic stem cells may be obtained from the transplant recipient (autologous HCT) or a donor (allogeneic [allo-] HCT). They can be harvested from bone marrow, peripheral blood, or umbilical cord blood shortly after delivery of neonates. Although cord blood is an allogeneic source, the stem cells in it are considered antigenically “naive” and thus are associated with a lower incidence of rejection or graft-versus-host disease.

The goal of autologous HCT in patients with autoimmune diseases is to eliminate self-reactive lymphocytes (lymphoablation) and generate new, self-tolerant lymphocytes. While evidence for the use of allo-HCT for autoimmune diseases is currently limited, the goal is to possibly eliminate genetic susceptibility to the autoimmune disease, potentially resulting in a cure.

Comparators
Comparators consist of conventional medication therapy. Most patients with autoimmune disorders respond to conventional therapies, which consist of anti-inflammatory agents, immunosuppressants, and immunomodulating drugs; however, conventional drug therapies are not curative, and a proportion of patients suffer from autoimmune diseases that range from severe to recalcitrant to rapidly progressive.

Outcomes
Outcomes of interest include progression-free survival (PFS), overall survival (OS), improvement in clinical symptoms, adverse events, and treatment-related mortality (TRM).

Timing
Follow-up for one year is standard to measure treatment-related adverse events and mortality. Several years of follow-up are necessary to determine the efficacy of treatment.

Setting
HCT is performed in a tertiary care center. Primary care practitioners and rheumatologists manage the care of patients with autoimmune diseases.

Study Selection Criteria
Methodologically credible studies were selected using the following principles:
  a. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
  b. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
  c. To assess long-term outcomes and adverse effects, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
  d. Studies with duplicative or overlapping populations were excluded.
  e. Recent reviews have summarized the research to date using HCT to treat a number of autoimmune diseases.3,4

In March 2009, patients with an autoimmune disease who had undergone HCT were registered in the European Group for Blood and Marrow Transplantation (EBMT)/European League Against Rheumatism database. The database included 1031 with the clinical indications of multiple sclerosis (MS; n=379), systemic sclerosis (n=207), systemic lupus erythematosus (SLE;
n=92), rheumatoid arthritis (RA; n=88), juvenile idiopathic arthritis (JIA; n=70), idiopathic thrombocytopenic purpura (n=23), and Crohn disease (n=23).4

**Multiple Sclerosis**

**Randomized Controlled Trials**

An RCT, Autologous Stem Cell Transplantation in Multiple Sclerosis, which compared HCT with mitoxantrone for treatment of MS, was published by Mancardi et al (2015).5 Due to low patient enrollment, this trial’s protocol, initially designed as a phase 3 study evaluating disability progression, was amended to a phase 2 study with a new primary outcome of disease activity, as measured by the number of new T2 magnetic resonance imaging (MRI) lesions in four years posttreatment. Eligibility for the trial was limited to the following criteria: secondary progressive or relapsing-remitting multiple sclerosis (RRMS), a documented worsening of symptoms during the last year, and lack of response to conventional therapy. Twenty-one patients were randomized to autologous HCT (n=9) or medical therapy (mitoxantrone) (n=12). Follow-up data were collected every 6 months for 48 months. Data were not available for four patients; missing data were imputed in the intention-to-treat analysis of the primary outcome. The median number of new T2 MRI lesions was 2.5 in the HCT group and 8 in the conventional therapy group (rate ratio, 0.21; 95% confidence interval [CI], 0.10 to 0.48, p<0.001). Among secondary outcomes, the annualized relapse rate was significantly lower in the HCT group (19%) compared with the conventional therapy group (60%; p<0.03). There was no statistically significant difference between groups in the rate of disease progression (defined as increase of >1 point in Expanded Disability Status Scale [EDSS] score if baseline was 3.5 to 5.5 or increase of >0.5 if baseline 5.5 to 6.5) or change in disability status.

**Systematic Reviews**

A systematic review by Reston et al (2011) evaluated the safety and efficacy of autologous HCT in patients with progressive MS refractory to conventional medical treatment (Table 1).6 Fourteen studies met inclusion criteria, of which eight case series met inclusion criteria for the primary outcome of PFS, with a median follow-up of at least two years. The other six studies were included for a summary of mortality and morbidity rates. The studies differed in the types and intensities of conditioning regimens used before HCT, with five studies using an intermediate-intensity regimen and three using high-intensity regimens. All studies were rated moderate quality. Across the eight-case series, there was substantial heterogeneity. Most patients (77%) had secondary progressive MS, although studies also included patients with primary progressive, progressive-relapsing, and RRMS. Results are presented in Table 2.

Sormani et al (2017) conducted a systematic review and meta-analysis on the use of autologous HCT for the treatment of patients with severe treatment-refractory MS (Table 1).7 The studies differed in types and intensities of conditioning regimens used before HCT: low (n=2), intermediate (n=7), high (n=4), and mixed (n=2). Quality assessment of included studies was not discussed. The rate of progression at two and five years were calculated, as well as treatment-related and overall mortality (Table 2). The pooled proportion of patients with no evidence of disease activity at 2 years was 83% (range 70% to 92%) and at 5 years was 67% (range 59% to 70%).

**Table 1. Characteristics of Meta-Analyses on the Use of Autologous HCT for Multiple Sclerosis**

<table>
<thead>
<tr>
<th>Study</th>
<th>Dates</th>
<th>Studies</th>
<th>Participants</th>
<th>N (range)</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reston (2011)6</td>
<td>Through Feb 2009</td>
<td>1 database 13 cohort</td>
<td>Patients with progressive and treatment-refractory multiple sclerosis</td>
<td>428 (5 to 169)</td>
<td>Median: 24 months</td>
</tr>
<tr>
<td>Sormani (2017)7</td>
<td>1995 to 2016</td>
<td>1 RCT 14 cohort</td>
<td>Patients with severe and treatment-refractory multiple sclerosis</td>
<td>764 (7 to 178)</td>
<td>Median: 42 months</td>
</tr>
</tbody>
</table>

HCT: hematopoietic cell transplantation
Table 2. Results of Meta-Analyses on the Use of Autologous HCT for Multiple Sclerosis

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Median follow-up</th>
<th>PFS, % (95% CI)</th>
<th>Sub-population</th>
<th>N</th>
<th>TRM, N (%)</th>
<th>Non-TRM, N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reston (2011)</td>
<td>102</td>
<td>39 months</td>
<td>79.4 (69.9 to 86.5)</td>
<td>Cohort studies</td>
<td>259</td>
<td>7 (2.7)</td>
<td>6 (2.3)</td>
</tr>
<tr>
<td>Intermediate-intensity conditioning</td>
<td>61</td>
<td>24 months</td>
<td>44.6 (26.5 to 64.3)</td>
<td>Database</td>
<td>169</td>
<td>9 (5.3)</td>
<td>6 (3.5)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>N</th>
<th>2-Year PR, % (95% CI)</th>
<th>N</th>
<th>5-Year PR, % (95% CI)</th>
<th>N</th>
<th>Pooled TRM, % (95% CI)</th>
<th>OM, % (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>764</td>
<td>17.1 (9.7 to 24.5)</td>
<td>679</td>
<td>23.3 (14.8 to 43.0)</td>
<td>764</td>
<td>2.1 (1.3 to 3.4)</td>
<td>1.0 (0.7 to 1.5)</td>
</tr>
</tbody>
</table>

* a pooled TRM defined as number of deaths within 100 days of transplant/number of transplants
* b OM defined as total number deaths/number of patient-years
CI: confidence interval; OM: overall mortality; PFS: progression free survival; PR: progression rate; TRM: treatment-related mortality.

Nonrandomized Studies
Select nonrandomized studies are described below.

Fassas et al (2011) reported on the long-term results of a single-center study that investigated the effect of HCT on the treatment of MS (Table 3). PFS and TRM are presented in Table 4. The median time to progression was 11 years (range, 0-22 years) for patients with active central nervous system disease and 2 years for patients without (range, 0-6 years). Improvements by 0.5 to 5.5 (median, 1) EDSS points were observed in 16 cases, lasting for a median of 2 years. In nine of these patients, EDSS scores did not progress above baseline scores. Gadolinium-enhancing lesions were significantly reduced after mobilization but were maximally and persistently diminished post-HCT.

Shevchenko et al (2012) reported on the results of a prospective, open-label, single-center study that analyzed the safety and efficacy of autologous HCT with a reduced-intensity conditioning regimen with different types of MS (Tables 3 and 4). Patients underwent early, conventional, and salvage/late transplantation. Efficacy was evaluated based on clinical and QOL outcomes. All patients, except one, responded to treatment. At long-term follow-up (mean, 46 months), the overall clinical response regarding disease improvement or stabilization was 80%. The estimated PFS rate at 5 years was 92% in the group after early transplant and 73% in the group after conventional/salvage transplant (p=0.01). No active, new, or enlarging lesions on were found on MRI without disease progression. All patients who did not have disease progression did not receive therapy during the postransplantation period. HCT was accompanied by a significant improvement in QOL, with statistically significant changes in most QOL parameters (p<0.05). A subsequent 2015 publication reported on 64 patients participating in this trial who had at least 36 months of follow-up (median, 62 months). (Another 35 patients had a shorter follow-up, and the remainder were lost to follow-up.) Thirty (47%) of the 64 patients improved by at least 0.5 points on the EDSS score compared with baseline. Among the other patients, 29 (45%) were stable, and 5 (7%) experienced worsening disease.

Mancardi et al (2012) reported on 74 consecutive patients with MS treated with autologous HCT following an intermediate-intensity conditioning regimen during the period from 1996 to 2008 (Table 3). Thirty-six patients had secondary progressive disease and 25 had RRMS. Clinical and MRI outcomes were reported (Table 4). The median follow-up was 48.3 months (range, 0.8-126 months). After 5 years, 66% of patients remained stable or improved. Among patients with follow-up more than 1 year, 8 (31%) of 25 subjects with RRMS had a 6- to 12-month confirmed EDSS score improvement more than 1 point after HCT compared with 1 (3%) of 36 patients with a secondary progressive disease course (p=0.009). Among the 18 cases with a follow-up more than 7 years, 8 (44%) remained stable or had sustained improvement, while 10 (56%), after an
initial period of stabilization or improvement (median duration, 3.5 years), showed a slow disability progression.

A single-center case series by Burt et al (2015) reported on 151 patients, 123 with RRMS and 28 with secondary progressive MS (Tables 3 and 4). Patients were treated with nonmyeloablative HCT between 2003 and 2014. Six patients were not included in the outcome analysis (lost to follow-up and nonreproducible neurologic findings). The remaining 145 patients were followed for a median of 2 years (range, 6 months to 5 years). Change in EDSS score was the primary outcome. A decrease of at least 1.0 point was considered a significant improvement and an increase of at least 1.0 point was considered a significant progression. There was a statistically significant improvement in EDSS score for the group as a whole compared with the pretransplant mean score of 4.0, decreasing to a mean EDSS score of 2.5 at 3, 4, and 5 years. In post hoc analysis, patients most likely to have statistically significant improvements in EDSS scores were those with RRMS, with duration of disease of ten years or less, and those without sustained fever during HCT.

A multicenter case series by Burman et al (2014) reported on 48 patients with aggressive RRMS (defined as a disease with high relapse frequency, and who failed conventional therapy) (Tables 3 and 4). Patients underwent autologous HCT. At the 5-year follow-up, relapse-free survival was 87%, and the EDSS score PFS (defined as a deterioration in EDSS score of <0.5 points) was 77%.

Atkins et al (2016) published a phase 2 trial investigating the use of immunosuppression and autologous HCT for the treatment of aggressive MS (Table 3). Inclusion criteria were: poor prognosis, ongoing disease activity, and EDSS score between 3.0 and 6.0. Twenty-four patients enrolled PFS and TRM are presented in Table 4. During the extended follow-up period, without the use of disease-modifying drugs, no signs of central nervous system inflammation were detected clinically or radiologically. Clinical relapses did not occur among the 23 surviving patients in 179 patient-years of follow-up. Moreover, 33% of the patients experienced grade 2 toxic effects and 58% experienced grade 1 transplantation-related toxic effects.

Results from the High-Dose Immunosuppression and Autologous Transplantation for Multiple Sclerosis trial were published by Nash et al (2017) (Tables 3 and 4). The trial evaluated 24 patients with MS who were treated with high-dose immunosuppression and autologous HCT. Outcomes were PFS (91%; 90% CI, 75% to 97%), clinical relapse-free survival (87%; 90% CI, 69% to 95%), and MRI activity-free survival (86%; 90% CI, 68% to 95%). Patients experienced high rates of adverse events: 92% had grade 3, and 100% had grade 4 adverse events. The majority of adverse events occurred between the start of conditioning and day 29 in the trial.

Muraro et al (2017) conducted a retrospective cohort study of patients with MS treated with HCT between 1995-2006 (Table 3). Data was collected from 25 centers in 13 European countries. Results are presented in Table 4. Factors associated with neurological progression included age, progressive versus relapsing MS, and >2 previous therapies.

Table 3. Characteristics of Observational Studies of HCT for MS

<table>
<thead>
<tr>
<th>Study</th>
<th>Study Design</th>
<th>Country</th>
<th>Participants</th>
<th>N</th>
<th>Median years (range) follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fassas (2011)</td>
<td>Case series</td>
<td>Greece</td>
<td>Patients with aggressive MS treated with HCT</td>
<td>35</td>
<td>11 (2 to 15)</td>
</tr>
<tr>
<td>Shevchenko (2012)</td>
<td>Case series</td>
<td>Russia</td>
<td>Patients with relapsing/remitting or progressive MS treated with HCT</td>
<td>99</td>
<td>4 (NR)</td>
</tr>
<tr>
<td>Shevchenko (2015)</td>
<td>Case series</td>
<td>Italy</td>
<td>Patients with MS treated with HCT</td>
<td>74</td>
<td>4 (0.8 to 10)</td>
</tr>
<tr>
<td>Mancardi et al (2012)</td>
<td>Case series</td>
<td>Sweden</td>
<td>Patients with aggressive MS treated with HCT</td>
<td>41</td>
<td>4 (1 to 9)</td>
</tr>
</tbody>
</table>
Hematopoietic Cell Transplantation for Autoimmune Diseases

<table>
<thead>
<tr>
<th>Study</th>
<th>Follow-up</th>
<th>PFS, % (95% CI)</th>
<th>TRM, N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fassas (2011)</td>
<td>15 years</td>
<td>All: 25 (NR)</td>
<td>2 (5.7%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Active MRI lesions: 44 (NR)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No active MRI lesions: 10 (NR)</td>
<td></td>
</tr>
<tr>
<td>Shevchenko (2012)</td>
<td>8 years</td>
<td>80 (68 to 88)</td>
<td>0</td>
</tr>
<tr>
<td>Shevchenko (2015)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mancardi et al (2012)</td>
<td>4 years</td>
<td>NR</td>
<td>2 (2.7)</td>
</tr>
<tr>
<td>Burt (2015)</td>
<td>5 years</td>
<td>68 (NR)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>4 years</td>
<td>87 (78 to 93)</td>
<td>0</td>
</tr>
<tr>
<td>Atkins (2016)</td>
<td>3 years</td>
<td>70 (47 to 84)</td>
<td>1 (4.2)</td>
</tr>
<tr>
<td>Nash (2017)</td>
<td>5 years</td>
<td>91 (75 to 97)</td>
<td>0</td>
</tr>
<tr>
<td>Muraro (2017)</td>
<td>5 years</td>
<td>All: 46 (42 to 54)</td>
<td>8 (2.8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relapsing: 73 (57 to 88)</td>
<td></td>
</tr>
</tbody>
</table>

CI: confidence intervals; HCT: hematopoietic cell transplantation; MRI: magnetic resonance imaging; MS: multiple sclerosis; NR: not reported; PFS: progression-free survival; TRM: treatment-related mortality.

Section Summary: MS

Evidence for the use of HCT in patients with MS consists of an RCT and many single-arm studies. The RCT compared HCT (n=9) with mitoxantrone (n=12). The primary outcome was the number of new T2 lesions detected by MRI. The HCT group developed statistically fewer lesions than the mitoxantrone group. Outcomes in the single-arm studies included PFS, relapse-free survival, disease activity-free survival, disease stabilization, number of new lesions, and improvements in EDSS scores. While improvements were seen in all outcomes compared with baseline, there were no comparative treatments. Adverse event rates were high, studies reporting treatment-related death rates ranging from 0% to 4%.

Systemic Sclerosis/Scleroderma

Systematic Reviews

A review by Milanetti et al (2011) summarized 8, phase 1 and 2 clinical studies using autologous HCT to treat systemic sclerosis.17 The number of patients in each study ranged from 6 to 57. The proportion of patients across the studies achieving a 25% decrease in the Rodnan Skin Score (RSS) ranged from 60% to 100%. Pooled analyses were not conducted.

Host et al (2017) conducted a systematic review of autologous HCT for the treatment of systemic sclerosis.18 The literature search, conducted through March 2016, identified 9 studies (2 RCTs and 7 observational studies) for inclusion. The RCTs reported improvements in progression- and event-free survival (EFS) and all studies reported improvements in modified RSS. However, TRM rates ranged from 0% to 23% with higher rates found with higher doses of cyclophosphamide or myeloablative conditioning regimens. No pooled analysis was conducted.

Shouval et al (2018) conducted a meta-analysis of 4 studies (3 RCTs and 1 retrospective comparative study) on the use of autologous HCT compared with cyclophosphamide alone for the treatment of systemic sclerosis.19 Quality assessment of the three RCTs found that two of the
RCTs had low-risk in the randomization methods and outcome reporting, one RCT was unclear in randomization methods, and all three were high-risk since blinding of patients and outcome assessors was not conducted. Meta-analyses of the RCTs showed that all-cause mortality favored HCT (risk ratio 0.6 [95% CI: 0.4 to 0.9]) and TRM favored cyclophosphamide alone (risk ratio 10.8 [95% CI: 1.4 to 85.7]).

**Randomized Controlled Trials**

An open-label, randomized, controlled phase 2 trial (ASSIST; Burt et al [2011]) evaluated the safety and efficacy of autologous nonmyeloablative HCT compared with the standard of care (cyclophosphamide) (Table 5). The primary outcome was an improvement at 12 months, which was defined as a decrease in modified RSS (<25% for those with initial modified RSS >14) or an increase in forced vital capacity (FVC) of more than 10% (Table 6). Patients in the control group with disease progression (>25% increase in modified RSS or decrease of >10% in FVC) despite treatment with cyclophosphamide could switch to HCT 12 months after enrollment. Patients allocated to HCT (n=10) improved at or before the 12-month follow-up compared with none of the 9 patients allocated to cyclophosphamide (p<0.001). Treatment failure (i.e., disease progression without interval improvement), occurred in eight of nine controls but did not occur in any of the ten patients treated by HCT (p<0.001). After long-term follow-up (mean, 2.6 years) of patients allocated to HCT, all but 2 patients had sustained improvement in modified RSS and FVC, with the longest follow-up of 60 months. Seven patients allocated to cyclophosphamide switched treatment groups at a mean of 14 months after enrollment and underwent HCT without complication; all improved after HCT. Four of these patients, followed for at least 1 year, had a mean (standard deviation [SD]) decrease in modified RSS from 27 (SD=15.5) to 15 (SD=7.4), an increase in FVC from 65% (20.6%) to 76% (26.5%), and an increase in total lung capacity from 81% (14.0%) to 88% (13.9%). Data for 11 patients, with a follow-up of to 2 years after HCT, suggested that the improvements in modified RSS (p<0.001) and FVC (p<0.03) persisted.

Results of the Autologous Stem Cell Transplantation International Scleroderma (ASTIS) trial (ISRCTN54371254) were published by van Laar et al (2014), (Tables 5 and 6). ASTIS was a phase 3 RCT comparing autologous HCT with cyclophosphamide for the treatment of systemic scleroderma. A total of 156 patients were recruited between March 2001 and October 2009. Median follow-up was 5.8 years (interquartile range, 4.1-7.8 years). The primary endpoint was EFS, defined as the time in days from randomization until the occurrence of death due to any cause or the development of persistent major organ failure (heart, lung, kidney). Main secondary endpoints included TRM, toxicity, and disease-related changes in modified RSS, organ function, body weight, and QOL scores. The internal validity (risk of bias) of ASTIS was assessed according to the U.S. Preventive Services Task Force criteria for randomized trials. The trial was rated as poor-quality according to this framework because of 2 flaws: outcome assessment was not masked to patients or assessors, and 18 (24%) of 75 of the control group discontinued intervention because of death, major organ failure, adverse events, or nonadherence. Furthermore, the trial design permitted crossover after the second year, but whether any patients did so and were analyzed as such is not mentioned. Finally, the authors reported the use of unspecified concomitant medications or other supportive care measures was allowed at the discretion of the investigator, adding further uncertainty to the results. Of the 53 primary endpoint events recorded, 22 were in the HCT group (19 deaths, 3 irreversible organ failures; 8 patients died of treatment-related causes in the first year, 9 of disease progression, 1 of cerebrovascular disease, 1 of malignancy) and 31 were in the control group (23 deaths, 8 irreversible organ failures, 7 of whom died later); 19 patients died of disease progression, 4 of cardiovascular disease, 5 of malignancy, 2 of other causes). The data showed patients treated with HCT experienced more events in the first year but appeared to have better long-term EFS than the controls, with Kaplan-Meier curves for OS crossing at about 2 years after treatment, with the OS rate at that time estimated at 85%. According to the Kaplan-Meier curves, at 5 years, the OS rate was estimated at 66% in the control group and estimated at 80% in the HCT group (p-value unknown). Time-varying hazard ratios (modeled with treatment by time interaction) for EFS were 0.35 (95% CI, 0.15 to 0.74) at 2 years and 0.34 (95% CI, 0.16 to 0.74) at 4 years, supporting a benefit of HCT compared with pulsed cyclophosphamide. Severe or life-
threatening grade 3 or 4 adverse events were reported in 51 (63%) of the HCT group and 30 (37%) by intention-to-treat, \( p=0.002 \) of the control group.

Sullivan et al (2018) conducted an RCT comparing autologous HCT with cyclophosphamide for the treatment of scleroderma (Table 5).\(^22\) The trial was originally designed for 226 patients, but due to low accrual, a total of 75 patients participated. Of the 36 patients randomized to receive HCT, 27 completed the trial per protocol (3 died and 6 withdrew prematurely). Of the 39 patients randomized to receive cyclophosphamide alone, 19 completed the trial per protocol (11 died and 9 withdrew prematurely). The primary outcome was a global rank composite score. This score does not measure disease activity or severity but performs a pairwise comparison of the following: death, EFS, FVC, Disability Index of the Health Assessment Questionnaire, and the modified RSS. There was more percent pairwise comparisons favoring HCT over cyclophosphamide alone at 4- and 4.5-years follow-up (Table 6). The following disease progression events were significantly higher among patients receiving cyclophosphamide alone: initiating disease-modifying antirheumatic drugs, congestive heart failure leading to treatment, and pulmonary arterial hypertension. The following disease progression events were not significantly different among the two treatment groups: arrhythmia, pericardial effusion, renal crisis, and myositis. Comparisons in mortality rates are presented in Table 6.

### Table 5. Characteristics of RCTs of HCT for Systemic Sclerosis

<table>
<thead>
<tr>
<th>Study; Trial</th>
<th>Countries</th>
<th>Sites</th>
<th>Dates</th>
<th>Participants</th>
<th>Active</th>
<th>Comparator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burt (2011);(^{20}) ASSIST</td>
<td>United States</td>
<td>1</td>
<td>2006 to 2009</td>
<td>Adult patients &lt;60 yrs with diffuse SSc; mRSS &gt;15; internal organ involvement</td>
<td>High-dose intravenous cyclophosphamide 200 mg/kg; intravenous rabbit antithymocyte-globulin 6.5 mg/kg total dose; aHCT (n=10)</td>
<td>6 monthly treatments with intravenous pulsed cyclophosphamide (1000 mg/m(^2)) (n=9)</td>
</tr>
<tr>
<td>Van Laar (2014);(^{21}) ASIS</td>
<td>9 European countries and Canada</td>
<td>29</td>
<td>2001 to 2009</td>
<td>Adult patients with diffuse cutaneous SSc; maximum duration 4 years; minimum mRSS &gt;15; internal organ involvement</td>
<td>High-dose intravenous cyclophosphamide 200 mg/kg; intravenous rabbit antithymocyte-globulin 7.5 mg/kg total dose; aHCT (n=79)</td>
<td>12 monthly treatments with intravenous pulsed cyclophosphamide (750 mg/m(^2)) (n=77)</td>
</tr>
<tr>
<td>Sullivan (2018);(^{22}) SCOT</td>
<td>United States and Canada</td>
<td>26</td>
<td>2005 to 2011</td>
<td>Adult patients with scleroderma; maximum duration 5 years; active interstitial lung disease and scleroderma-related renal disease</td>
<td>Total body irradiation (800 cGy); cyclophosphamide (120 mg/kg); equine antithymocyte globulin (90 mg/kg); aHCT (n=36)</td>
<td>12 monthly treatments with intravenous pulsed cyclophosphamide (n=39)</td>
</tr>
</tbody>
</table>

aHCT: autologous hematopoietic cell transplantation; mRSS: modified Rodnan skin scores; RCT: randomized controlled trial; SSc: systematic sclerosis.
Table 6. Results of RCTs of HCT for Systemic Sclerosis

<table>
<thead>
<tr>
<th>Study</th>
<th>Efficacy Outcomes</th>
<th>Adverse Events</th>
<th>TRM n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mRSS at 1 year mean (SD)</td>
<td>PVC at 1 year Mean % (SD)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Events, 1 yr</td>
<td>Events, 4 yrs</td>
<td>Deaths, 1 yr</td>
</tr>
<tr>
<td>Burt (2011)^20; ASSIST</td>
<td>15 (7.9)</td>
<td>74 (15.7)</td>
<td>NR</td>
</tr>
<tr>
<td>cyclophosphamide van Laar (2014)^21; ASIS</td>
<td>22 (14.2)</td>
<td>61 (19.8)</td>
<td>NR</td>
</tr>
<tr>
<td>aHCT</td>
<td>13</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>cyclophosphamide</td>
<td>8</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>Relative Risk (95% CI)</td>
<td>1.6 (0.7 to 4.4)</td>
<td>0.7 (0.4 to 1.3)</td>
<td>1.5</td>
</tr>
<tr>
<td>Sullivan (2018)^22; SCOT</td>
<td>Global Rank Composite Score, at 4 Years</td>
<td>Global Rank Composite Score, at 4.5 Years</td>
<td>&gt;Grade 3</td>
</tr>
<tr>
<td>aHCT</td>
<td>68%</td>
<td>67%</td>
<td>2.0</td>
</tr>
<tr>
<td>cyclophosphamide</td>
<td>32%</td>
<td>33%</td>
<td>1.2</td>
</tr>
<tr>
<td>p-value</td>
<td>0.008</td>
<td>0.01</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Death or Respiratory, Renal, or Cardiac Failure, n (%)</td>
<td></td>
<td>Death from any Cause, n (%)</td>
<td></td>
</tr>
<tr>
<td>aHCT</td>
<td>At 4 years: 10 (28)</td>
<td>At 4.5 years: 6 (17)</td>
<td></td>
</tr>
<tr>
<td>cyclophosphamide</td>
<td>At 4 years: 20 (51)</td>
<td>At 4.5 years: 11 (28)</td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>0.06</td>
<td>0.28</td>
<td></td>
</tr>
</tbody>
</table>

aHCT: autologous hematopoietic cell transplantation; CI: confidence interval; RCT: randomized controlled trial; TRM: treatment-related mortality.

Nonrandomized Studies

Vonk et al (2008) reported on the long-term results of 28 patients with severe diffuse cutaneous systemic sclerosis who underwent autologous HCT from 1998 to 2004. There were 1 transplant-related death and 1 death due to progressive disease, leaving 26 patients for evaluation. After a median follow-up of 5.3 years (range, 1-7.5 years), 81% (n=21/26) of the patients demonstrated a clinically beneficial response. Skin sclerosis was measured with a modified RSS, and a significant (i.e., >25%) decrease (i.e., improvement) was achieved in 19 of 26 patients after 1 year and in 15 of 16 after 5 years. At study baseline, 65% of patients had significant lung involvement; all pulmonary function parameters remained stable after transplant at 5- and 7-year follow-ups. Based on the World Health Organization Performance Status, which reflects the effect of HCT on the combination of functional status, skin, lung, heart, and kidney involvement, the percentage of patients with a Performance Status score of 0 increased to 56% from 4% at baseline. The estimated survival rate at 5 years was 96.2% (95% CI, 89% to 100%) and at 7 years was 84.8% (95% CI, 70.2% to 100%); and the EFS rate (survival without mortality, relapse, or progression of systemic sclerosis resulting in major organ dysfunction) was 64.3% (95% CI, 47.9% to 86%) at 5 years and 57.1% (95% CI, 39.3% to 83%) at 7 years. For comparison, an international meta-analysis published in 2005 estimated the 5-year mortality rate in patients with severe systemic sclerosis at 40%.

Nash et al (2007) reported on the long-term follow-up of 34 patients with diffuse cutaneous systemic sclerosis with significant visceral organ involvement who were enrolled in a multi-institutional pilot study between 1997 and 2005 and underwent autologous HCT. Of the 34 patients, 27 (79%) survived 1 year and were evaluable for response (there were 8 transplant-related deaths and 4 systemic sclerosis-related deaths). Of the 27 evaluable patients, 17 (63%) had sustained responses at a median follow-up of 4 years (range, 1-8 years). Skin biopsies showed a statistically significant decrease in dermal fibrosis compared with baseline (p<0.001) and, in general, lung, heart, and kidney function remained stable. Overall function as assessed in 25 patients using the Disability Index of the modified Health Assessment Questionnaire showed improvement in 19, and disease response was observed in the skin of 23 of 25 and lungs of 8 of 27 patients. Estimated OS and PFS rates were both 64% at 5 years.
Henes et al (2012) reported on 26 consecutive patients with systemic sclerosis scheduled for autologous HCT between 1997 and 2009. The main outcome variable was a response to treatment (reduction of modified RSS by 25%) at 6 months. Secondary endpoints were transplant-related mortality and PFS. At 6 months, significant skin and lung function improvement assessed on the modified RSS was achieved in 78.3% of patients. The overall response rate was 91% and some patients even improved after month 6. Three patients died between mobilization and conditioning treatment owing to severe disease progression and one treatment-related. Seven patients relapsed during the 4.4 years of follow-up. The PFS rate was 74%. Four patients died during follow-up, with the most frequent causes of death being pulmonary and cardiac complications of systemic sclerosis.

Section Summary: Systemic Sclerosis/Scleroderma

Evidence for the use of HCT in patients with systemic sclerosis/scleroderma consists of three RCTs and several nonrandomized studies. All three RCTs report long-term improvements in clinical outcomes such as modified RSS and FVC, as well as overall mortality in patients receiving autologous HCT compared with patients receiving chemotherapy alone. However, due to small sample sizes in two of the RCTs, only the large RCT shows statistical significance. TRM and adverse events are higher among the patients receiving HCT compared with patients receiving chemotherapy alone.

Systemic Lupus Erythematosus

Systematic Review

Leone et al (2018) conducted a systematic review of clinical and laboratory studies using autologous HCT for patients with SLE. The literature search, conducted through 2014, identified 25 studies (n=279 patients): 2 prospective, 10 retrospective, and 13 case reports. Quality assessment of included studies was not discussed in the publication. Heterogeneity between studies was high ($I^2=87\%$). The only pooled analysis conducted was on 5 studies reporting deaths, resulting in overall mortality of 8.3% in a mean follow-up of 36 months.

Observational Studies

Select case series from the systematic review and series published after the review are described below.

Burt et al (2006) published results on the largest single-center series using HCT for SLE in the United States. Between 1997 through 2005, investigators enrolled 50 patients (mean age, 30 years; 43 women, 7 men) with SLE refractory to standard immunosuppressive therapies and either organ- or life-threatening visceral involvement in a single-arm trial. All subjects had at least 4 of 11 American College of Rheumatology criteria for SLE and required more than 20 mg/d of prednisone or its equivalent, despite the use of cyclophosphamide. Patients underwent autologous HCT following a lymphoablative conditioning regimen. Two patients died after mobilization, yielding a TRM rate of 4% (2/50). After a mean follow-up of 29 months (range, 6 months to 7.5 years), the 5-year OS rate was 84% and the probability of disease-free survival was 50%. Several parameters of SLE activity improved, including renal function, Systemic Lupus Erythematosus Disease Activity Index score, antinuclear antibody, anti-double-stranded DNA, complement C3, and C4 levels, and carbon monoxide diffusion lung capacity. The investigators suggested these results justified a randomized trial comparing immunosuppression plus autologous HCT with continued standard of care.

Song et al (2011) reported on the efficacy and toxicity of autologous HCT for 17 patients with SLE after 7 years follow-up. The OS and PFS rates were used to assess the efficacy and toxicity levels of the treatment. The median follow-up was 89 months (range, 33-110 months). The probabilities of 7-year OS and PFS were 82.4% and 64.7%, respectively. The principal adverse events included allergy, infection, elevated liver enzymes, bone pain, and heart failure. Two patients died, 1 due to severe pneumonia and the other due to heart failure at 33 and 64...
months after transplantation, respectively. The authors concluded their seven-year follow-up results suggested that autologous HCT was beneficial for SLE patients.

Leng et al (2017) reported on 24 patients with severe SLE who received high-dose immunosuppressive therapy and HCT. Patients were followed for ten years. One patient died following treatment. At the 6-month follow-up, 2 patients had achieved partial remission, and 21 patients had achieved remission. At the 10-year follow-up, the OS rate was 86%. 16 patients remained in remission, 4 were lost to follow-up, 2 had died, and 1 had active disease.

Cao et al (2017) reported on 22 patients with SLE who underwent autologous peripheral blood HCT. At 5-year follow-up, PFS was 68% and OS was 95%. At last follow-up, ten patients had relapsed. Adverse events included infections, secondary autoimmunity, lymphoma, and malignancy. The authors noted difficulty in distinguishing between conditions caused by relapse or by the transplantation.

Burt et al (2018) reported on 30 patients with refractory, chronic, corticosteroid-dependent SLE who underwent autologous HCT. Outcomes were measured at six months and yearly through five years. Disease remission was achieved by 24 patients. The SLE Disease Activity Index and QOL 36-Item Short Form Health Survey improved significantly at each follow-up compared with baseline. No TRM was reported. Five grade 4 and 60 grade 3 adverse events were reported.

Section Summary: SLE
Evidence for the use of autologous HCT to treat patients with SLE consists of a systematic review and numerous case series. The systematic review did not conduct a quality assessment and reported high heterogeneity among the studies. A 4% TRM rate was reported in two studies. High rates of remission were reported at various follow-up times and adverse event rates were high. While HCT has shown beneficial effects on patients with SLE, further investigation of more patients is needed.

Juvenile Idiopathic or Rheumatoid Arthritis
A review article by Saccardi et al (2008) on HCT for autoimmune diseases has summarized the experience with JIA and RA as follows. More than 50 patients with JIA have been reported to the EBMT Registry. The largest cohort study initially used a single conditioning regimen and, thereafter, a modified protocol. Overall drug-free remission rate was approximately 50%. Some late relapses have been reported, and only partial correction of growth impairment has been seen. The frequency of HCT for RA has decreased significantly since 2000, due to the introduction of new biologic therapies. Most patients who have undergone HCT have had persistence or relapse of disease activity within six months of transplant.

Silva et al (2018) reported on 16 patients with JIA refractory to standard therapy or who had failed autologous HCT, who underwent allo-HCT. Patients experienced significant improvements in arthritis and QOL, with 11 children achieving drug-free remission at last follow-up. At a median follow-up of 29 months, 1 patient died of probable sepsis following elective surgery and 1 died of invasive fungal infection, for a TRM rate of 12.5%.

Section Summary: JIA or RA
Evidence for the use of HCT on patients with JIA consists of data from an EBMT Registry (n>50) and a case series. Different conditioning regimens were used among the patients in the registry, with remission rates averaging 50%. However, relapse has been reported within six months in many cases, and new biologic therapies that provide improved outcomes are available for these patients. The case series of patients with refractory JIA reported a high rate of drug-free remission (69%), with a TRM rate of 12.5%.

Chronic Inflammatory Demyelinating Polyneuropathy
Several review articles have summarized experience with HCT in the treatment of chronic inflammatory demyelinating polyneuropathy. In general, the evidence includes a few
case reports describing outcomes for autologous HCT in patients who failed standard treatments such as corticosteroids, intravenous immunoglobulins, and plasma exchange. While improvements were reported, some with long-term follow-up, the numbers of patients undergoing the procedure are small, and the potential for serious adverse events is a concern.

**Section Summary: Chronic Inflammatory Demyelinating Polyneuropathy**
Evidence for the use of HCT to treat patients with chronic inflammatory demyelinating polyneuropathy consists of case reports. Additional investigations are needed due to the toxicity associated with this procedure.

**Type 1 Diabetes Systematic Review**
El-Badawy and El-Badri (2016) published a meta-analysis on the use of HCT to treat diabetes. The literature search, conducted through August 2015, identified 22 studies for inclusion; study design of included studies was not consistently reported. Fifteen of the studies (n=300 patients) involved patients with type 1 diabetes; 7 studies (n=224 patients) involved patients with type 2 diabetes. The quality of the selected studies was assessed using Cochrane criteria, however, results of the risk of bias assessment were not reported in the publication. The mean follow-up in the studies ranged from 6 to 48 months (median, 12 months). Table 7 presents comparisons of C-peptide levels (C-peptide measures islet cell mass, and an increase after HCT indicates preservation of islet cells) and hemoglobin A1c levels after 12-month follow-up. Adverse events were reported in 22% of the patients, with no reported mortality. Reviewers concluded that remission of diabetes is possible and safe with stem cell therapy, patients with previously diagnosed ketoacidosis are not good candidates for HCT, and that early-stage patients may benefit more from HCT. Large-scale well-designed randomized studies considering stem cell type, cell number, and infusion method are needed.

<table>
<thead>
<tr>
<th>Diabetes Subgroups</th>
<th>No. of Studies</th>
<th>No. of Patients</th>
<th>SMD (95% CI) C-Peptide</th>
<th>No. of Studies</th>
<th>No. of Patients</th>
<th>SMD (95% CI) HbA1c</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UCB</td>
<td>4</td>
<td>56</td>
<td>1.07 (0.67 to 1.48)</td>
<td>4</td>
<td>61</td>
<td>0.05 (-0.30 to 0.41)</td>
</tr>
<tr>
<td>UC-MSC</td>
<td>1</td>
<td>15</td>
<td>-0.91 (-1.67 to -0.16)</td>
<td>1</td>
<td>15</td>
<td>1.19 (0.41 to 1.98)</td>
</tr>
<tr>
<td>BM-HSC</td>
<td>4</td>
<td>97</td>
<td>-1.37 (-1.69 to -1.05)</td>
<td>3</td>
<td>96</td>
<td>3.87 (3.29 to 4.44)</td>
</tr>
<tr>
<td>BM-MSC</td>
<td>1</td>
<td>10</td>
<td>-1.18 (-2.15 to -0.22)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>IS-ADSc + BM-HSC</td>
<td>2</td>
<td>21</td>
<td>-1.01 (-1.73 to -0.30)</td>
<td>NA</td>
<td>NA</td>
<td>0.93 (0.27 to 1.59)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>12</td>
<td>199</td>
<td>-0.57 (-1.73 to -0.35)</td>
<td>10</td>
<td>193</td>
<td>1.09 (0.83 to 1.35)</td>
</tr>
</tbody>
</table>

Adapted from El-Badawy and El-Badri (2016). BM-HSC: bone marrow hematopoietic stem cells; BM-MNC: bone marrow mononuclear stem cells; BM-MSC: bone marrow mesenchymal stem cells; CI: confidence interval; HbA1c: hemoglobin A1c; HCT: hematopoietic cell transplantation; IS-ADSc: insulin secreting-adipose derived stem cells; NA: not applicable; PD-MSC: placenta-derived mesenchymal stem cells; SMD: standard mean difference; UCB: umbilical cord blood; UC-MSC: umbilical cord mesenchymal stem cells.

**Case Series**
Several case series have evaluated autologous HCT in patients with new-onset type 1 diabetes; there were no published comparative studies. Although a substantial proportion of patients tended to become insulin-free after HCT, remission rates were high.

Cantu-Rodríguez et al (2016) published a study of 16 patients with type 1 diabetes who received a less toxic conditioning regimen and transplantation. The outpatient procedures were...
completed without severe complications. At the 6-month follow-up, 3 (19%) were nonresponders, 6 (37%) partially independent from insulin, and 7 (44%) were completely independent of insulin. Hemoglobin A1c levels decreased by a mean of -2.3% in the insulin-independent group.

Xiang et al (2015) published data on 128 patients ages 12 to 35 years who had been diagnosed with type 1 diabetes no more than 6 weeks before study enrollment.\(^\text{40}\) After a mean follow-up of 28.5 months (range, 15-38 months), 71 (55%) patients were considered to be insulin-free. These patients had a mean remission period of 14.2 months. The other 57 (45%) patients were insulin-dependent. The latter group included 27 patients with no response to treatment and another 30 patients who relapsed after a transient remission period. Adverse events included ketoacidosis and renal dysfunction (one patient each); there was no transplant-related mortality. In multiple logistic regression analysis, factors independently associated with becoming insulin-free after autologous HCT were of a younger age at onset of diabetes, lower tumor necrosis factor α levels, and higher fasting C-peptide levels.

A case series by Snarski et al (2016) reported on 24 patients with a diagnosis of type 1 diabetes who underwent autologous HCT.\(^\text{41}\) Mean age was 26.5 years (range, 18-34 years). After treatment, 20 (87%) of 23 patients went into diabetes remission, defined as being insulin-free with normoglycemia for at least 9.5 months. The median time of remission was 31 months (range, 9.5-80 months). Mean insulin doses remained significantly lower than baseline doses at two and three years, but the insulin doses returned to pre-HCT levels at years four and five. Among 20 patients remaining in follow-up at the time of data analysis for publication, 4 (20%) remained insulin-free. In an update published by Walicka et al (2018), after 6 years of follow-up, 1 patient remained insulin-free.\(^\text{42}\) Adverse events include neutropenic fever in 12 (50%) patients. There were four cases of sepsis, including a fatal case of *Pseudomonas aeruginosa* sepsis. There was also a case of pulmonary emphysema after insertion of a central venous catheter.

Couri et al (2009) reported on the results of a prospective case series evaluating autologous HCT in 23 patients with type 1 diabetes (age range, 13-31 years) diagnosed in the 6 weeks before transplant based on clinical findings including hyperglycemia and confirmed by measurement of serum levels of anti-glutamic acid decarboxylase antibodies.\(^\text{43}\) At a mean follow-up of 29.8 months (range, 7-58 months) after autologous nonmyeloablative HCT, C-peptide levels increased significantly, and most patients achieved insulin independence with good glycemic control. Twenty patients without previous ketoacidosis and not receiving corticosteroids during the preparative regimen became insulin-free. Twelve patients had maintained insulin independence for a mean of 31 months (range, 14-52 months), and 8 patients relapsed and resumed low-dose insulin. In the continuously insulin-independent group, hemoglobin A1c levels were less than 7.0%. There was no transplant-related mortality.

**Section Summary: Type 1 Diabetes**

Evidence for the use of HCT to treat diabetes consists of several case series and a meta-analysis of 22 studies. The meta-analysis revealed that HCT is more effective in patients with type 1 diabetes compared with type 2 diabetes, and when the treatment is administered soon after the diagnosis. Certain factors limit the conclusions that can be drawn about the overall effectiveness of HCT to treat diabetes due to heterogeneity in the stem cell types, cell number infused, and infusion methods. Case series reported short-term effectiveness in achieving insulin independence; however, long-term studies showed that a majority of patients returned to insulin within four to six years.

**Other Autoimmune Diseases**

**Crohn Disease**

Phase 2/3 protocols are being developed for Crohn disease.

Hawkey et al (2015) have conducted the only RCT (ASTIC trial) evaluating the effect of HCT on Crohn disease.\(^\text{44}\) Patients were randomized to receive either immunosuppression and HCT (n=23) or control (HCT deferred for 1 year, n=22). The primary endpoint was remission defined as Crohn...
Disease Activity Index <150; no use of corticosteroids or immunosuppressive drugs or biologics for three months; and no endoscopic or radiologic evidence of active disease. At one year follow-up, two patients in the treatment group and one patient in the control group achieved remission (p=0.6). Adverse events were reported in 76 patients receiving HCT and in 38 controls. One HCT patient died.

Lindsay et al (2017) reported additional analyses on the ASTIC trial participants, combining the treated patients and the control patients who underwent deferred HCT. Outcomes were three month steroid free clinical remission at one year and degree of endoscopic healing at one year. Three-month steroid-free clinical remission was achieved by 13 of 34 (38%; 95% CI, 22% to 55%) patients who had data available. Complete endoscopic healing was seen in 19 of 38 patients (50%; 95% CI, 34% to 66%). However, serious adverse events (76) were experienced in 23 of 40 patients.

Brierley et al (2018) published a review of patients in the EBMT Registry undergoing autologous NCT for Crohn disease (n=82) who had failed a median of 6 lines of drug therapy. At a median follow-up of 41 months, 68% achieved either complete remission or significant improvement in symptoms. One patient died of causes relating to the transplant (cytomegalovirus infection, sepsis, and organ failure). At a median of 10 months follow-up, 73% resumed medical therapy for Crohn disease.

Additional Autoimmune Diseases
For the remaining autoimmune diseases (e.g., immune cytopenias, relapsing polychondritis), sample sizes are too small to draw conclusions.

A case series of 7 patients with myasthenia gravis was reported by Bryant et al (2016). Using the Myasthenia Gravis Foundation of America clinical classification, all patients achieved complete stable remission, with follow-up from 29 to 149 months. The authors concluded that these positive long-term results warranted further investigation of HCT for patients with myasthenia gravis.

Section Summary: Other Autoimmune Diseases
Evidence for the use of HCT to treat Crohn disease consists of an RCT and a retrospective review of registry data. While remission was experienced by some patients receiving HCT, adverse event rates were high, and many patients had a recurrence of symptoms within one year.

Evidence for the use of HCT to treat other autoimmune diseases consists of small retrospective studies. Information from larger prospective studies is needed.

Summary of Evidence
For individuals with MS who receive HCT, the evidence includes an RCT and several case series. The relevant outcomes are OS, health status measures, QOL, and TRM and morbidity. The phase 2 RCT compared HCT with mitoxantrone, and the trial reported intermediate outcomes (number of new T2 MRI lesions); the group randomized to HCT developed significantly fewer lesions than the group receiving conventional therapy. The findings of the case series revealed improvements in clinical parameters following HCT compared with baseline. Adverse event rates were high, and most studies reported treatment-related deaths. Controlled trials (with appropriate comparator therapies) reporting on clinical outcomes are needed to demonstrate efficacy. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with multiple sclerosis who receive HCT, the evidence includes a randomized controlled trial (RCT) and several case series. The relevant outcomes are overall survival (OS), health status measures, quality of life (QOL), and treatment-related mortality (TRM) and morbidity. The phase 2 RCT compared HCT with mitoxantrone, and the trial reported intermediate outcomes (number of new T2 magnetic resonance imaging lesions); the group randomized to HCT developed significantly fewer lesions than the group receiving conventional therapy.
therapy. The findings of the case series revealed improvements in clinical parameters following HCT compared with baseline. Adverse event rates were high, and most studies reported treatment-related deaths. Controlled trials (with appropriate comparator therapies) reporting on clinical outcomes are needed to demonstrate efficacy. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with systemic sclerosis/scleroderma who receive HCT, the evidence includes three RCTs and observational studies. The relevant outcomes are OS, symptoms, health status measures, QOL, and TRM and morbidity. All three RCTs compared cyclophosphamide conditioning plus autologous HCT with cyclophosphamide alone. Patients in the RCTs were adults <60 years of age, maximum duration of disease of 5 years, with modified Rodnan skin scores >15, and internal organ involvement. Patients with severe and irreversible organ involvement were excluded from the trials. Short-term results of the RCTs show higher rates of adverse events and TRM among patients receiving autologous HCT compared with patients receiving chemotherapy alone. However, long-term improvements (four years) in clinical outcomes such as modified Rodnan skin scores and forced vital capacity, as well as overall mortality in patients receiving HCT compared with patients receiving cyclophosphamide alone, were consistently reported in all RCTs. Due to sample size limitations in two of the RCTs, statistical significance was found only in the larger RCT. The evidence is sufficient to determine that the technology results in a meaningful improvement in net health outcomes.

For individuals with systemic lupus erythematosus who receive HCT, the evidence includes a systematic review and case series. The relevant outcomes are OS, symptoms, QOL, and TRM and morbidity. Studies were heterogeneous in conditioning regimens and source of cells. The largest series (n=50) reported an overall 5-year survival rate of 84% and the probability of disease-free survival was 50%. Additional data are needed from controlled studies to demonstrate efficacy. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with juvenile idiopathic or rheumatoid arthritis who receive HCT, the evidence includes registry data and a case series. The relevant outcomes are OS, symptoms, QOL, and TRM and morbidity. The registry included 50 patients with juvenile idiopathic or rheumatoid arthritis. The overall drug-free remission rate was approximately 50% in the registry patients and 69% in the smaller case series. Additional data are needed from controlled studies to demonstrate efficacy. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with chronic inflammatory demyelinating polyneuropathy who receive HCT, the evidence includes case reports. The relevant outcomes are OS, symptoms, health status measures, QOL, and TRM and morbidity. Additional data are needed from controlled studies to demonstrate efficacy. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with type 1 diabetes who receive HCT, the evidence includes case series and a meta-analysis of 22 studies. The relevant outcomes are OS, symptoms, health status measures, QOL, and TRM and morbidity. While a substantial proportion of patients tended to become insulin-free after HCT, remission rates were high. A meta-analysis further revealed that HCT is more effective in patients with type 1 diabetes compared with type 2 diabetes and when HCT is administered soon after the diagnosis. Certain factors limit the conclusions that can be drawn about the overall effectiveness of HCT in treating diabetes; those factors are heterogeneity in the stem cell types, cell number infused, and infusion methods. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with other autoimmune diseases (e.g., Crohn disease, immune cytopenias, relapsing polychondritis) who receive HCT, the evidence includes one RCT and small retrospective studies. The relevant outcomes are OS, symptoms, health status measures, QOL, and TRM and morbidity. The RCT was conducted on patients with Crohn disease. At one year
follow-up, one patient in the control group and two patients in the HCT group achieved remission. Data are needed from additional controlled studies to demonstrate efficacy. The evidence is insufficient to determine the effects of the technology on health outcomes.

Supplemental Information
Practice Guidelines and Position Statements
The American Society of Transplantation (2017) convened a consensus conference of experts to address issues related to the transplantation of hepatitis C virus (HCV) viremic solid organs into HCV non-viremic recipients. Key findings and recommendations are summarized in Table 8.

Table 8. American Society of Transplantation Consensus Conference - Use of HCV Viremic Donors

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Key Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition of HCV positive</td>
<td>HCV -viremic reflecting a positive NAT should be adopted</td>
</tr>
<tr>
<td>Data interpretation</td>
<td>HCV antibody status alone limits interpretation of outcomes of transplantation of HCV “positive” organs</td>
</tr>
<tr>
<td>Transmission and Treatment</td>
<td>Highest risk for unexpected HCV transmission is associated with organ donation from a person who injected drugs within the eclipse or pre-viremic period</td>
</tr>
<tr>
<td>OPTN policy</td>
<td>No current policies prevent transplantation of HCV-viremic organs into HCV non-viremic recipients</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>Transplantation of HCV-viremic organs into HCV non-viremic recipients should be conducted under site specific IRB approved protocols with multi-step informed consent.</td>
</tr>
</tbody>
</table>

American Academy of Neurology et al
A review of guidelines from the AAN and the American College of Rheumatology found no mention of stem cell transplantation for multiple sclerosis (MS), lupus, rheumatoid arthritis, or juvenile idiopathic arthritis. The AAN (2016) affirmed the statements in the Myasthenia Gravis Foundation of America’s consensus guidelines for the management of myasthenia gravis. The consensus guidelines did not discuss hematopoietic cell transplantation (HCT) as a therapeutic option. The AAN (2018) published guidelines on the use of disease-modifying medications for patients with MS; the AAN does not discuss HCT as a therapeutic option for MS.

American Society for Blood and Marrow Transplantation
The American Society for Blood and Marrow Transplantation (2015) published consensus guidelines on the use of HCT to treat specific conditions in and out of the clinical trial setting. Table 8 lists guidelines for specific indications addressed in this evidence review.

Table 8. Recommendations for the Use of HCT to Treat Autoimmune Diseases

<table>
<thead>
<tr>
<th>Indications for HCT in Pediatric Patients (Generally &lt;18 y)</th>
<th>Allogeneic HCT</th>
<th>Autologous HCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Juvenile rheumatoid arthritis</td>
<td>D</td>
<td>R</td>
</tr>
<tr>
<td>Systemic sclerosis</td>
<td>D</td>
<td>R</td>
</tr>
<tr>
<td>Other autoimmune and immune dysregulation disorders</td>
<td>R</td>
<td>N</td>
</tr>
<tr>
<td>Indications for HCT in Adults &gt;18 y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td>N</td>
<td>D</td>
</tr>
<tr>
<td>Systemic sclerosis</td>
<td>N</td>
<td>D</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>N</td>
<td>D</td>
</tr>
<tr>
<td>Systemic lupus erythematosus</td>
<td>N</td>
<td>D</td>
</tr>
<tr>
<td>Crohn disease</td>
<td>N</td>
<td>D</td>
</tr>
<tr>
<td>Polymyositis/dermatomyositis</td>
<td>N</td>
<td>D</td>
</tr>
</tbody>
</table>

D: developmental; HCT: hematopoietic cell transplantation; N: not generally recommended; R: standard of care, rare indication.

European Group for Blood and Marrow Transplantation
The EBMT (2012) updated its guidelines on HCT for severe autoimmune diseases. EBMT recommended as follows: “HSCT[hematopoietic stem cell transplantation] should be considered as a therapeutic option at second line or beyond for patients with severe ADs.
[autoimmune diseases] progressing despite standard established and/or approved therapy” (level of evidence II). The following conditions should be met if HCT is chosen for treatment: referral to a center with Joint Accreditation Committee of International Society for Cellular Therapy and EBMT accreditation; when possible, HCT should be conducted within a phase 2 or 3 trial; if such a phase 2 or 3 trial is not available, then a multidisciplinary team should meet with patients to discuss HCT and non-HCT treatment options.

The EBMT (2015) issued additional guidelines on HCT for severe ADs, focusing on immune monitoring and biobanking. To standardize clinical HCT protocols, EBMT developed guidelines for “good laboratory practice” in relation to procuring, processing, storing, and analyzing biologic specimens of patients with ADs undergoing HCT. The guidance provides a table that specifies the type of biologic sample (e.g., serum, biopsy, cerebrospinal fluid), sample tests, testing methods (e.g., enzyme-linked immunosorbent assay, fluorescent activated cell sorter), and timing of testing for the following ADs: MS, systemic sclerosis, systemic lupus erythematosus, Crohn disease, type 1 diabetes, and arthritis.

**European League Against Rheumatism**

The European League against Rheumatism (2017) convened a task force to update recommendations for the treatment of systemic sclerosis. The task force consisted of clinical experts from Europe and the United States. In regard to HCT, the task force concluded: “HSCT should be considered for the treatment of selected patients with rapidly progressive systemic sclerosis at risk of organ failure.” However, due to the high risk of treatment-related adverse events and mortality, “careful selection of patients with systemic sclerosis for this kind of treatment and the experience of the medical team are of key importance.” (Strength of recommendation: A)

**American College of Gastroenterology**


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

Not applicable.

**Medicare National Coverage**

There are numerous ADs, and the Centers for Medicare & Medicaid Services has not issued a national coverage determination for stem cell transplantation for each disease. A general national coverage determination for stem cell transplantation (110.23; formerly 110.8.1) states as listed in Table 9.

<table>
<thead>
<tr>
<th>Covered and Noncovered Indications for HCT</th>
<th>Covered and Noncovered Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationally covered indications</td>
<td></td>
</tr>
<tr>
<td>Allogeneic HCT</td>
<td>“Effective … 1978, for the treatment of leukemia, leukemia in remission, or aplastic anemia when it is reasonable and necessary”</td>
</tr>
<tr>
<td></td>
<td>“Effective … 1985, for the treatment of severe combined immunodeficiency disease (SCID) and for the treatment of Wiskott-Aldrich syndrome”</td>
</tr>
<tr>
<td></td>
<td>“Effective … 2010, for the treatment of Myelodysplastic Syndromes (MDS) pursuant to Coverage with Evidence Development (CED) in the context of a Medicare-approved, prospective clinical study”</td>
</tr>
<tr>
<td>Autologous HCT</td>
<td>“Effective … 1989, [autologous HCT] is considered reasonable and necessary … for the following conditions and is covered under Medicare for patients with: 1. Acute leukemia in remission who have a high probability of relapse and who have no human leukocyte antigens (HLA)-matched; 2. Resistant non-Hodgkin’s lymphomas or those presenting with poor prognostic features following an initial response; 3. Recurrent or refractory neuroblastoma; or,”</td>
</tr>
</tbody>
</table>
4. Advanced Hodgkin's disease who have failed conventional therapy and have no HLA-matched donor."

“Effective ... 2000, single [autologous HCT] is only covered for Durie-Salmon Stage II or III patients that fit the following requirements:

- Newly diagnosed or responsive multiple myeloma. This includes those patients with previously untreated disease, those with at least a partial response to prior chemotherapy (defined as a 50% decrease either in measurable paraprotein [serum and/or urine] or in bone marrow infiltration, sustained for at least 1 month), and those in responsive relapse; and
- Adequate cardiac, renal, pulmonary, and hepatic function.”

“Effective ... 2005, when recognized clinical risk factors are employed to select patients for transplantation, high dose melphalan (HDM) together with [autologous HCT] is reasonable and necessary for Medicare beneficiaries of any age group with primary amyloid light chain (AL) amyloidosis who meet the following criteria:

- Amyloid deposition in 2 or fewer organs; and,
- Cardiac left ventricular ejection fraction (EF) greater than 45%.”

Nationally noncovered indications

Allogeneic HCT

“Effective ... 1996, through January 26, 2016, allogeneic [HCT] is not covered as treatment for multiple myeloma.”

Autologous HCT

“Insufficient data exist to establish definite conclusions regarding the efficacy of [autologous HCT] for the following conditions:

a) Acute leukemia not in remission;
b) Chronic granulocytic leukemia;
c) Solid tumors (other than neuroblastoma);
d) Up to October 1, 2000, multiple myeloma;
e) Tandem transplantation (multiple rounds of [autologous HCT]) for patients with multiple myeloma;
f) Effective ... 2000, non-primary AL amyloidosis; and,
g) Effective ... 2000 through March 14, 2005, primary AL amyloidosis for Medicare beneficiaries age 64 or older.

In these cases, [autologous HCT] is not considered reasonable and necessary ... and is not covered under Medicare.”

HCT: hematopoietic cell transplantation.

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 10.

<table>
<thead>
<tr>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randomized Study of Different Non-myoelobative Conditioning Regimens with Hematopoietic Stem Cell Support in Patients with Scleroderma (ASSIST-IIb)</td>
<td>160</td>
<td>Sep 2019</td>
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<tr>
<td>Hematopoietic Stem Cell Therapy for Patients with Inflammatory Multiple Sclerosis Failing Alternate Approved Therapy: A Randomized Study</td>
<td>110</td>
<td>Dec 2018</td>
</tr>
<tr>
<td>Non-myoelobative Autologous Hematopoietic Stem Cell Transplantation in Patients with Chronic Inflammatory Demyelinating Polyneuropathy: A Phase II Trial</td>
<td>80</td>
<td>Dec 2018</td>
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<tr>
<td>Outpatient Hematopoietic Grafting in Patients with Multiple Sclerosis Employing Autologous Non-cryopreserved Peripheral Blood Stem Cells: a Feasibility Study</td>
<td>200</td>
<td>Dec 2019</td>
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<tr>
<td>Autologous Unselected Hematopoietic Stem Cell Transplantation for Refractory Crohn’s Disease</td>
<td>50</td>
<td>Mar 2020</td>
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<tr>
<td>Evaluation of the Safety and Efficacy of Reduced-Intensity Immoablation and Autologous Hematopoietic Stem Cell Transplantation (AHSCIT) in Multiple Sclerosis</td>
<td>15</td>
<td>May 2020</td>
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<tr>
<td>Autologous Bone Marrow Transplant in Chronic Insulin Dependent Diabetic Patients Phase II Clinical Trial</td>
<td>100</td>
<td>Jun 2020</td>
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</tbody>
</table>
An Open-Label, Phase II Multicenter Cohort Study of Immunoablation with Cyclophosphamide and Antithymocyte-Globulin and Transplantation of Autologous CD34-Enriched Hematopoietic Stem Cells versus Currently Available Immunosuppressive /Immunomodulatory Therapy for Treatment of Refractory Systemic Lupus Erythematosus

Safety and Efficacy of Immuno-Modulation and Autologous Bone-Marrow Derived Stem Cell Transplantation for the Treatment of Multiple Sclerosis

High dose Chemotherapy and Transplantation of 43+ Selected Stem Cells for Progressive Systemic Sclerosis - Modification According to Manifestation

Randomized Autologous Hematopoietic Stem Cell Transplantation Versus Alemtuzumab for Patients with Relapsing-Remitting Multiple Sclerosis

Autologous Stem Cell Transplantation for Progressive Systemic Sclerosis: a Prospective Non-interventional Approach Across Europe (NISSC) for the Autoimmune Diseases Working Party of the EBMT

References


**Documentation for Clinical Review**

**Please provide the following documentation (if/when requested):**

- Referring physician history and physical
- Stem Cell 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
  - Specific issues identified during the transplant evaluation
  - Consultation reports/letters (when applicable)
  - Correspondence from referring physicians (when applicable)
Identification of donor for allogeneic related 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. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

**MN/IE**

The following services may be considered medically necessary in certain instances and investigational in others. Services may be considered medically necessary when policy criteria are met. Services may be considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>CPT®</td>
<td>38205</td>
<td>Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic</td>
</tr>
<tr>
<td>CPT®</td>
<td>38206</td>
<td>Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous</td>
</tr>
<tr>
<td>CPT®</td>
<td>38207</td>
<td>Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage</td>
</tr>
<tr>
<td>CPT®</td>
<td>38208</td>
<td>Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor</td>
</tr>
<tr>
<td>CPT®</td>
<td>38209</td>
<td>Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor</td>
</tr>
<tr>
<td>CPT®</td>
<td>38210</td>
<td>Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest; T-cell depletion</td>
</tr>
<tr>
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<td>38211</td>
<td>Transplant preparation of hematopoietic progenitor cells; tumor cell depletion</td>
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<tr>
<td>CPT®</td>
<td>38212</td>
<td>Transplant preparation of hematopoietic progenitor cells; red blood cell removal</td>
</tr>
<tr>
<td>CPT®</td>
<td>38213</td>
<td>Transplant preparation of hematopoietic progenitor cells; platelet depletion</td>
</tr>
<tr>
<td>CPT®</td>
<td>38214</td>
<td>Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion</td>
</tr>
<tr>
<td>CPT®</td>
<td>38215</td>
<td>Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer</td>
</tr>
<tr>
<td>CPT®</td>
<td>38220</td>
<td>Diagnostic bone marrow; aspiration(s)</td>
</tr>
<tr>
<td>Type</td>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
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<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>38221</td>
<td>Diagnostic bone marrow; biopsy(ies)</td>
</tr>
<tr>
<td></td>
<td>38222</td>
<td>Diagnostic bone marrow; biopsy(ies) and aspiration(s)</td>
</tr>
<tr>
<td></td>
<td>38230</td>
<td>Bone marrow harvesting for transplantation; allogeneic</td>
</tr>
<tr>
<td></td>
<td>38232</td>
<td>Bone marrow harvesting for transplantation; autologous</td>
</tr>
<tr>
<td></td>
<td>38240</td>
<td>Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor</td>
</tr>
<tr>
<td></td>
<td>38241</td>
<td>Hematopoietic progenitor cell (HPC); autologous transplantation</td>
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<tr>
<td>HCPCS</td>
<td>S2150</td>
<td>Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre and post-transplant care in the global definition</td>
</tr>
<tr>
<td>ICD-10 Procedure</td>
<td>07DQ0ZZ</td>
<td>Extraction of Sternum Bone Marrow, Open Approach</td>
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<tr>
<td></td>
<td>07DQ3ZZ</td>
<td>Extraction of Sternum Bone Marrow, Percutaneous Approach</td>
</tr>
<tr>
<td></td>
<td>07DR0ZZ</td>
<td>Extraction of Iliac Bone Marrow, Open Approach</td>
</tr>
<tr>
<td></td>
<td>07DR3ZZ</td>
<td>Extraction of Iliac Bone Marrow, Percutaneous Approach</td>
</tr>
<tr>
<td></td>
<td>07DS0ZZ</td>
<td>Extraction of Vertebral Bone Marrow, Open Approach</td>
</tr>
<tr>
<td></td>
<td>07DS3ZZ</td>
<td>Extraction of Vertebral Bone Marrow, Percutaneous Approach</td>
</tr>
<tr>
<td></td>
<td>30243G0</td>
<td>Transfusion of Autologous Bone Marrow into Central Vein, Percutaneous Approach</td>
</tr>
<tr>
<td></td>
<td>30243G2</td>
<td>Transfusion of Allogeneic Related Bone Marrow into Central Vein, Percutaneous Approach</td>
</tr>
<tr>
<td></td>
<td>30243G3</td>
<td>Transfusion of Allogeneic Unrelated Bone Marrow into Central Vein, Percutaneous Approach</td>
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<tr>
<td></td>
<td>30243G4</td>
<td>Transfusion of Allogeneic Unspecified Bone Marrow into Central Vein, Percutaneous Approach</td>
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<tr>
<td></td>
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<td>Transfusion of Autologous Cord Blood Stem Cells into Central Vein, Percutaneous Approach</td>
</tr>
<tr>
<td></td>
<td>30243X2</td>
<td>Transfusion of Allogeneic Related Cord Blood Stem Cells into Central Vein, Percutaneous Approach</td>
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<td></td>
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<td>Transfusion of Allogeneic Related Hematopoietic Stem Cells into Central Vein, Percutaneous Approach</td>
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<td>Transfusion of Allogeneic Unrelated Hematopoietic Stem Cells into Central Vein, Percutaneous Approach</td>
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<td></td>
<td>30243Y4</td>
<td>Transfusion of Allogeneic Unspecified Hematopoietic Stem Cells into Central Vein, Percutaneous Approach</td>
</tr>
</tbody>
</table>

**Policy History**

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

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/28/2007</td>
<td>New Policy. Policy adopted from BCBSA MPP.</td>
<td>Benefit Guidelines from BSC COE program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical Policy Committee</td>
</tr>
</tbody>
</table>
Definitions of Decision Determinations

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**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 (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 also be directed to the Transplant Case Management Department. Please call 1-800-637-2066 ext. 3507708 or visit the Provider Portal www.blueshieldca.com/provider.

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.