**Policy Statement**

My5-FU™ assay testing or other types of assays for determining 5-fluorouracil (5-FU) area under the curve in order to adjust 5-FU dose for colorectal cancer patients or other cancer patients is considered *investigational*.

Testing for genetic variants in dipyrimidine dehydrogenase (DPYD) or thymidylate synthase (TYMS) genes to guide 5-FU dosing and/or treatment choice in patients with cancer is considered *investigational*.

**Policy Guidelines**

**Genetics Nomenclature Update**

The Human Genome Variation Society (HGVS) nomenclature is used to report information on variants found in DNA and serves as an international standard in DNA diagnostics. It is being implemented for genetic testing medical evidence review updates starting in 2017 (see Table PG1). The Society’s nomenclature is recommended by the Human Variome Project, the Human Genome Organization (HUGO), and by the Human Genome Variation Society itself.

The American College of Medical Genetics and Genomics (ACMG) and the Association for Molecular Pathology (AMP) standards and guidelines for interpretation of sequence variants represent expert opinion from both organizations, in addition to the College of American Pathologists. These recommendations primarily apply to genetic tests used in clinical laboratories, including genotyping, single genes, panels, exomes, and genomes. Table PG2 shows the recommended standard terminology—“pathogenic,” “likely pathogenic,” “variant of uncertain significance,” “likely benign,” and “benign”—to describe variants identified that cause Mendelian disorders.

**Table PG1. Nomenclature to Report on Variants Found in DNA**

<table>
<thead>
<tr>
<th>Previous</th>
<th>Updated</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mutation</td>
<td>Disease-associated variant</td>
<td>Disease-associated change in the DNA sequence</td>
</tr>
<tr>
<td>Variant</td>
<td>Disease-associated change in</td>
<td>Change in the DNA sequence</td>
</tr>
<tr>
<td></td>
<td>the DNA sequence</td>
<td></td>
</tr>
<tr>
<td>Familial variant</td>
<td>Disease-associated variant</td>
<td>Disease-associated variant identified in a proband for use in</td>
</tr>
<tr>
<td></td>
<td>identified in a proband for</td>
<td>subsequent targeted genetic testing in first-degree relatives</td>
</tr>
<tr>
<td></td>
<td>use in subsequent targeted</td>
<td></td>
</tr>
<tr>
<td></td>
<td>genetic testing in first-degree relatives</td>
<td></td>
</tr>
</tbody>
</table>

**Table PG2. ACMG-AMP Standards and Guidelines for Variant Classification**

<table>
<thead>
<tr>
<th>Variant Classification</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathogenic</td>
<td>Disease-causing change in the DNA sequence</td>
</tr>
<tr>
<td>Likely pathogenic</td>
<td>Likely disease-causing change in the DNA sequence</td>
</tr>
<tr>
<td>Variant of uncertain significance</td>
<td>Change in DNA sequence with uncertain effects on disease</td>
</tr>
<tr>
<td>Likely benign</td>
<td>Likely benign change in the DNA sequence</td>
</tr>
<tr>
<td>Benign</td>
<td>Benign change in the DNA sequence</td>
</tr>
</tbody>
</table>

ACMG: American College of Medical Genetics and Genomics; AMP: Association for Molecular Pathology.

**Genetic Counseling**

Experts recommend formal genetic counseling for patients who are at risk for inherited disorders and who wish to undergo genetic testing. Interpreting the results of genetic tests and understanding risk factors can be difficult for some patients; genetic counseling helps individuals understand the impact of genetic testing, including the possible effects the test results could have on the individual or their family members. It should be noted that genetic counseling may alter the utilization of genetic testing substantially and may reduce inappropriate testing; further,
genetic counseling should be performed by an individual with experience and expertise in genetic medicine and genetic testing methods.

Coding
Effective January 1, 2018, the following specific CPT codes may be used:

- **81230**: CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (e.g., drug metabolism), gene analysis, common variant(s) (e.g., *2, *22)
- **81231**: CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (e.g., drug metabolism), gene analysis, common variants (e.g., *2, *3, *4, *5, *6, *7)
- **81232**: DPYD (dihydropyrimidine dehydrogenase) (e.g., 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (e.g., *2A, *4, *5, *6)
- **81346**: TYMS (thymidylate synthetase) (e.g., 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (e.g., tandem repeat variant)

The following is a specific HCPCS “S” code for the My5-FU test:

- **S3722**: Dose optimization by area under the curve (AUC) analysis, for infusional 5-fluorouracil

**Description**

Variability in systemic exposure to 5-fluorouracil (5-FU) chemotherapy is thought to directly impact 5-FU tolerability and efficacy. The standard approach is dosing according to body surface area. Two alternative approaches have been proposed for modifying use of 5-FU: (1) dosing based on the determined area under the curve serum concentration target and (2) genetic testing for variants affecting 5-FU metabolism. For genetic testing, currently available polymerase chain reaction tests assess specific variants in genes encoding dihydropyrimidine reductase (DPYD) and thymidylate synthetase (TYMS) in the catabolic and anabolic pathways of 5-FU metabolism, respectively.

**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**

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service; laboratory-developed tests must meet the general regulatory standards of the Clinical Laboratory Improvement Amendments. My5-FU™ (Saladax Biomedical) and genetic testing for variants in DPYD and TYMS for predicting the risk of 5-FU toxicity and chemotherapeutic response (ARUP Laboratories) are available under the auspices of the Clinical Laboratory Improvement Amendments. Laboratories that offer laboratory-developed tests must be
Laboratory and Genetic Testing for Use of 5-Fluorouracil in Patients With Cancer

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licensed by the Clinical Laboratory Improvement Amendments for high-complexity testing. To date, the U.S. Food and Drug Administration has chosen not to require any regulatory review of this test.

Rationale

Background
5-Fluorouracil

The agent 5-FU is a widely used antineoplastic chemotherapy drug that targets thymidylate synthase (TYMS) enzyme, which is involved in DNA production. 5-FU has been used for many years to treat solid tumors (e.g., colon and rectal cancer, head and neck cancer). In general, the incidence of grade 3 or 4 toxicity (mainly neutropenia, diarrhea, mucositis, and hand-foot syndrome) increases with higher systemic exposure to 5-FU. Several studies also have reported statistically significant positive associations between 5-FU exposure and tumor response. In current practice, however, 5-FU dose is reduced when symptoms of severe toxicity appear but is seldom increased to promote efficacy.

Based on known 5-FU pharmacology, it is possible to determine a sampling scheme for the area under the curve (AUC) determination and to optimize an AUC target and dose-adjustment algorithm for a particular 5-FU chemotherapy regimen and patient population. For each AUC value or range, the algorithm defines the dose adjustment during the next chemotherapy cycle most likely to achieve the target AUC without overshooting and causing severe toxicity.

In clinical research studies, 5-FU blood plasma levels most recently have been determined by high-performance liquid chromatography or liquid chromatography coupled with tandem mass spectrometry. Both methods require expertise to develop an in-house assay and may be less amenable to routine clinical laboratory settings.

Measuring Exposure to 5-FU
Laboratory Testing

Patient exposure to 5-FU is most accurately described by estimating the AUC, the total drug exposure over a defined period of time. 5-FU exposure is influenced by the method of administration, circadian variation, liver function, and the presence of inherited dihydropyrimidine reductase (DPYD)-inactivating genetic variants that can greatly reduce or abolish 5-FU catabolism. As a result, both inter- and intrapatient variability in 5-FU plasma concentration during administration is high.

Determination of 5-FU AUC requires complex technology and expertise that may not be readily available in a clinical laboratory setting. In the U.S., a commercial immunoassay (My5-FU) can quantify plasma 5-FU concentration from a blood sample drawn during continuous infusion at steady state (18-44 hours after the start of infusion) and provide a dose-adjustment algorithm to maintain plasma 5-FU AUC between 20 and 30 mg/h/L during the next cycle.1

Genetic Testing

5-FU is a pyrimidine antagonist, similar in structure to the normal pyrimidine building blocks of RNA (uracil) and DNA (thymine). More than 80% of administered 5-FU is inactivated and eliminated via the catabolic pathway; the remainder is metabolized via the anabolic pathway.

Catabolism of 5-FU is controlled by the activity of DPYD. Because DPYD is a saturable enzyme, the pharmacokinetics of 5-FU are strongly influenced by the dose and schedule of administration.2 For example, 5-FU clearance is faster with continuous infusion than with bolus administration, resulting in very different systemic exposure to 5-FU during the course of therapy. Genetic variants in DPYD, located on chromosome 1, can lead to reduced 5-FU catabolism and increased toxicity. Many variants have been identified (e.g., IVS14+1G>A [also known as DPYD*2A], 2846A>T[D949V]). DPYD deficiency is an autosomal codominantly inherited trait.3
The anabolic pathway metabolizes 5-FU to an active form that inhibits DNA and RNA synthesis by competitive inhibition of TYMS or by incorporation of cytotoxic metabolites into nascent DNA. Genetic variants in TYMS can cause tandem repeats in the TYMS enhancer region (TSER). One variant leads to three tandem repeats (TSER*3) and has been associated with 5-FU resistance due to increased tumor TYMS expression compared with the TSER*2 variant (two tandem repeats) and wild-type forms.

**Literature Review**

The primary goal of pharmacogenomics testing and personalized medicine is to achieve better clinical outcomes compared with the standard of care. Drug response varies greatly between individuals, and genetic factors are known to play a role. However, in most cases, the genetic variation only explains a modest portion of the variance in the individual response because clinical outcomes are also affected by a wide variety of factors including alternate pathways of metabolism and patient- and disease-related factors that may affect absorption, distribution, and elimination of the drug. Therefore, assessment of clinical utility cannot be made by a chain of evidence from clinical validity data alone. In such cases, evidence evaluation requires studies that directly demonstrate that the pharmacogenomic test alters clinical outcomes; it is not sufficient to demonstrate that the test predicts a disorder or a phenotype.

Evidence reviews assess whether a medical test is clinically useful. A useful test provides information to make a clinical management decision that improves the net health outcome. That is, the balance of benefits and harms is better when the test is used to manage the condition than when another test or no test is used to manage the condition.

The first step in assessing a medical test is to formulate the clinical context and purpose of the test. The test must be technically reliable, clinically valid, and clinically useful for that purpose. Evidence reviews assess the evidence on whether a test is clinically valid and clinically useful. Technical reliability is outside the scope of these reviews, and credible information on technical reliability is available from other sources.

**Laboratory Testing to determine 5-fluorouracil Area Under the Curve for Dose Adjustment**

**Clinical Context and Proposed Clinical Utility**

The proposed clinical utility of laboratory testing is to use test results to guide 5-FU dosing so that the therapeutic impact is maximized and the toxicity is decreased.

The question addressed in this evidence review is: Can lab tests be used to guide 5-FU dosing to maximize therapeutic impact and minimize toxicity?

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

**Patients**
The relevant population of interest are patients with cancer who have an indication for 5-FU treatment.

**Interventions**
The test being considered is laboratory assays to determine 5-FU AUC.

**Comparators**
The following practice is currently being used to make decisions about dosing of 5-FU. This involves standard dosing by body weight, specifically body surface area (BSA)-based dosing.

**Outcomes**
The outcomes of interest are reductions in treatment-related morbidity related to 5-FU toxicity. Types of severe toxicity include neutropenia, diarrhea, mucositis, and hand-foot syndrome.
Timing
Specific survival outcomes may vary by type of cancer but generally, 1- to 2-year survival is a short-term outcome and 5- and 10-year survival is a long-term outcome. Treatment-related morbidity can be acute toxicity (≤14 days) or late toxicity (>14 days).

Setting
Patients would be tested in the oncology setting.

Simplifying Test Terms
There are three core characteristics for assessing a medical test. Whether imaging, laboratory, or other, all medical tests must be:

- Technically reliable
- Clinically valid
- Clinically useful.

Because different specialties may use different terms for the same concept, we are highlighting the core characteristics. The core characteristics also apply to different uses of tests, such as diagnosis, prognosis, and monitoring treatment.

Diagnostic tests detect the presence or absence of a condition. Surveillance and treatment monitoring are essentially diagnostic tests over a time frame. Surveillance to see whether a condition develops or progresses is a type of detection. Treatment monitoring is also a type of detection because the purpose is to see if treatment is associated with the disappearance, regression, or progression of the condition.

Prognostic tests predict the risk of developing a condition in the future. Tests to predict response to therapy are also prognostic. Response to therapy is a type of condition and can be either a beneficial response or adverse response. The term predictive test is often used to refer to a response to therapy. To simplify terms, we use prognostic to refer both to predicting a future condition or predicting response to therapy.

Technically Reliable
Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review, and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Kline et al (2014) assessed My5-FU in a retrospective study of patients with stage II and III (n=35) or stage IV or recurrent (n=49) colorectal cancer (CRC) who received 5-FU regimens at a single-center in the U. S.5 Thirty-eight patients chose pharmacokinetic monitoring with OnDose and 46 patients were dosed by BSA. Median progression-free survival did not differ by dosing strategy in stage IV or recurrent patients (14 months with AUC monitoring vs 10 months BSA dosing; p=0.16) but did differ in stage II and III patients (p=0.04). Thirty-seven percent of stage IV or recurrent patients in both dosing strategy groups experienced grade 3 toxicity. Among stage II and III patients, 32% of AUC-monitored patients and 69% of BSA-dosed patients experienced grade 3 toxicity (p=0.04). The onset of adverse events also was delayed in the AUC-monitored group (6-7 months) compared with the BSA-dose group (two months; p=0.01).

My5-FU was clinically validated for patients with CRC in an observational analysis reported by Saam et al (2011).6 Sequential patients (n=357) were treated with constant infusion 5-FU using current adjuvant or metastatic treatment protocols with or without bevacizumab. Samples were drawn at least two hours after the start of and before the end of each infusion and sent for
Sixty-two (17%) patients were studied longitudinally across 4 sequential sample submissions (i.e., 4, 5-FU treatment infusions), of which 3 (5%) were within the target AUC after the first infusion. By the fourth infusion, this percentage rose to 37%, and outliers were reduced. Use of bevacizumab did not affect results. Response and toxicity were not reported.

Section Summary: Clinically Valid
Several analyses of patients with CRC have evaluated the clinical validity of the My5-FU assay. In one study, the rate of severe toxicity was significantly lower in patients with stage II and III cancer who chose pharmacokinetic monitoring vs BSA monitoring but progression-free survival did not differ between groups in patients with stage IV or recurrent cancer. In another study, among patients studied longitudinally and monitored with My5-FU, 3% were within the target AUC after the first infusion, and this reached 37% by the fourth infusion.

Clinically Useful
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

Direct Evidence
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from randomized controlled trials (RCTs).

The results of single-arm trials of AUC-targeted 5-FU dose adjustment in advanced CRC patients have suggested consistently improved tumor response.7,8,9 Similar, although less compelling, results were seen in single-arm trials of AUC-targeted 5-FU dosing in head and neck cancer.10,11 The best contemporary evidence supporting AUC-targeted dosing consists of two RCTs, one enrolling patients with CRC and the other enrolling patients with head and neck cancer. No trials of any design were identified for 5-FU dose adjustment in other malignancies.

Gamelin et al (1998) developed a chart for weekly dose adjustment based on the results of an earlier, similar single-arm study (1996)12, in which dose was increased by prespecified increments and intervals up to a maximum dose or the first signs of toxicity. In an RCT enrolling patients with metastatic CRC, Gamelin et al (2008) reported significantly improved tumor response (33.6% vs 18.3%, respectively; p < 0.001) and a trend toward improved survival (40.5% vs 29.6%, respectively; p = 0.08) in the experimental arm using AUC-targeted dosing (by high-performance liquid chromatography) for single-agent 5-FU compared with fixed dosing.13 However, trialists also reported 18% grade 3 to 4 diarrhea in the fixed-dose control arm. In the latter 2 trials, the delivery over a longer time period for both 5-FU (22 hours vs 8 hours) and leucovorin (2 hours vs bolus), which is characteristic of currently recommended 5-FU treatment regimens, likely minimized toxicity.

The administration schedule used in the Gamelin et al (2008) trial13 is rarely currently used in clinical practice and is absent from current guidelines.6 Additional optimization studies would be needed to apply 5-FU exposure monitoring and AUC-targeted dose adjustment to a more standard single-agent 5-FU treatment regimen, with validation in a comparative trial vs a fixed-dose regimen.

Fety et al (1998), in an RCT of patients with locally advanced head and neck cancer, used a different method of dose adjustment and reported overall 5-FU exposures in head and neck cancer patients that were significantly reduced in the dose-adjustment arm compared with the fixed-dose arm.16 This reduced toxicity but did not improve clinical response. The dose-adjustment method in this trial might have been too complex because the 12 patients with protocol violations in this treatment arm (of 61 enrolled) all were related to 5-FU dose adjustment...
miscalculations. Because patients with protocol violations were removed from the analysis, results did not reflect “real-world” results of the dose-adjustment method. Also, the induction therapy regimen used two drugs, not the current standard of three, therefore, the generalizability of results to current clinical practice is limited.

Yang et al (2016) published a meta-analysis of data from the 2 RCTs described above (i.e., Gamelin et al [2008]13, and Fety et al [1998]), as well as from 3 observational studies.17 In a pooled analysis, the overall response rate was significantly higher with pharmacokinetic AUC-monitored 5-FU therapy than with standard BSA-based monitoring (odds ratio, 2.04; 95% confidence interval [CI], 1.41 to 2.95). In terms of toxicity, the incidence of diarrhea (three studies), neutropenia (three studies), and hand-foot syndrome (two studies) did not differ significantly between the pharmacokinetic and BSA monitoring strategies. The rate of mucositis was significantly lower in the BSA-monitored group (3 studies; odds ratio, 0.16; 95% CI, 0.04 to 0.63). Most data were from observational studies, which are subject to selection and observational biases.

Section Summary: Clinically Useful
No RCTs or nonrandomized comparative studies were identified comparing health outcomes in cancer patients who did and did not have 5-FU dose adjustment using the My5-FU assay and who were treated with chemotherapy regimens used in current clinical practice. A systematic review of the available literature found a significantly higher response rate with BSA-based monitoring and no significant difference in toxicity. Most data were from observational studies; RCTs were conducted in the 1980s when different chemotherapy protocols were used.

Testing for DPYD or TYMS Variants Affecting 5-FU Dose Adjustment
Clinical Context and Proposed Clinical Utility
The proposed clinical utility of genetic testing is to use test results to guide 5-FU dosing so that the therapeutic impact is maximized and the toxicity is decreased.

The question addressed in this evidence review is: Can genetic tests guide 5-FU dosing to maximize therapeutic impact and minimize toxicity?

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

Patients
The relevant population of interest are patients with cancer who have an indication for 5-FU treatment.

Interventions
The test being considered is genetic testing for variants (e.g., in DPYD and TYMS) affecting 5-FU metabolism.

Comparators
The following practice is currently being used to make decisions about dosing of 5-FU. This involves standard dosing by body weight, specifically BSA-based dosing.

Outcomes
The outcomes of interest are reductions in treatment-related morbidity related to 5-FU toxicity. Types of severe toxicity include neutropenia, diarrhea, mucositis, and hand-foot syndrome.

Timing
Specific survival outcomes may vary by type of cancer but generally, 1- to 2-year survival is a short-term outcome and 5- and 10-year survival is a long-term outcome. Treatment-related morbidity can be acute toxicity (≤14 days) or late toxicity (>14 days).
Setting
Patients would be tested in the oncology setting. Also, referral for genetic counseling is important for the explanation of the genetic disease, heritability, genetic risk, test performance, and possible outcomes.

Technically Reliable
Assessment of technical reliability focuses on specific tests and operators and requires a review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review, and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Toxicity
A number of studies have evaluated the association between variants in the DPYD and/or TYMS genes and 5-FU toxicity. Cancer types and specific variants studied differed across these reports. Several meta-analyses have been published. Li et al (2014) identified 7 cohort studies with a total of 946 patients with CRC. A pooled analysis of study findings found that DPYD variants correlated significantly with an increased risk of 5-FU-related toxicity. Also, Rosmarin et al (2014) identified 16 studies with a total of 4855 patients with CRC who were treated with capecitabine and other fluorouracil-based treatment regimens. Capecitabine toxicity was significantly associated with several DPYD alleles and several TYMS single nucleotide variants.

A key study was published by Schwab et al (2008). Trialists enrolled 683 patients who were receiving 5-FU for colon or other gastrointestinal cancers, cancers of unknown primary, or breast cancer in a genotype study. Seven different 5-FU regimens (monotherapy or in combination with folate or levamisole [not approved by the Food and Drug Administration]) administered by bolus or by infusion were included. Patients were genotyped for the DPYD splice site variant DPYD*2A (IVS14+1G>A), which leads to a nonfunctional enzyme, and for TYMS tandem repeats.

Sensitivity, specificity, and positive and negative predictive values for overall toxicity, diarrhea, mucositis, and leukopenia were calculated (see Table 1). Although heterozygosity for DPYD*2A had 99% specificity for serious toxicity, sensitivity ranged from 6% to 13%. Tandem repeats in TYMS were neither sensitive nor specific indicators of serious toxicity. Clinical factors also were examined for association with toxicity. Overall and in the group of 13 patients who were heterozygous for DPYD*2A, women were more likely than men to develop severe toxicity (overall odds ratio, 1.9; 95% CI, 1.26 to 2.87; p=0.002), most commonly mucositis. Bolus administration of 5-FU was a significant, independent predictor of severe toxicity overall.

Table 1. Grade 3 and 4 Adverse Events and DPYD and TYMS Genotypes

<table>
<thead>
<tr>
<th>Toxicity</th>
<th>DPYD<em>2A</em> (n=13), %</th>
<th>TYMS VNTR 2/3 or 3/3p (n=521), %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall toxicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensitivity</td>
<td>6</td>
<td>65</td>
</tr>
<tr>
<td>Specificity</td>
<td>99</td>
<td>21</td>
</tr>
<tr>
<td>Positive predictive value</td>
<td>46</td>
<td>14</td>
</tr>
<tr>
<td>Negative predictive value</td>
<td>85</td>
<td>76</td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensitivity</td>
<td>NR</td>
<td>57</td>
</tr>
<tr>
<td>Specificity</td>
<td>NR</td>
<td>22</td>
</tr>
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<td>6</td>
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<tr>
<td>Negative predictive value</td>
<td>NR</td>
<td>84</td>
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<tr>
<td>Mucositis</td>
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<tr>
<td>Sensitivity</td>
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<td>NR</td>
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<tr>
<td>Specificity</td>
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<tr>
<td>Negative predictive value</td>
<td>93</td>
<td>NR</td>
</tr>
<tr>
<td>Leukopenia</td>
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</tbody>
</table>
Laboratory and Genetic Testing for Use of 5-Fluorouracil in Patients With Cancer

<table>
<thead>
<tr>
<th>Toxicity</th>
<th>DPYD*2A (n=13), %</th>
<th>TYMS VNTR 2/3 or 3/3 (n=521),%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity</td>
<td>13</td>
<td>NR</td>
</tr>
<tr>
<td>Specificity</td>
<td>99</td>
<td>NR</td>
</tr>
<tr>
<td>Positive predictive value</td>
<td>31</td>
<td>NR</td>
</tr>
<tr>
<td>Negative predictive value</td>
<td>96</td>
<td>NR</td>
</tr>
</tbody>
</table>

Adapted from Schwab et al (2008).20

NR: not reported; VNTR: variable number of tandem repeats.

aHeterozygousDPYD*2Avs wt/wt.
bHomozygous (3R/3R) or mixed heterozygous (2R/3R) triple repeats vs homozygous double repeats (2/2).

Boige et al (2016) published a subgroup analysis of patients participating in an RCT.21 The RCT compared treatment with FOLFOX4 and FOLFOX4 plus cetuximab. A total of 1545 patients participated in the pharmacogenetics subgroup study and were genotyped on 25 DYPD variants. The primary endpoint was the development of grade 3 or higher 5-FU-related adverse events (hematologic and gastrointestinal combined). Two DYPD variants (D949V, V73231) were significantly associated with grade 3 or higher adverse events (p<0.001 for both).

Vásquez et al (2017) prospectively evaluated 197 patients who were treated with 5-FU between 2013 and 2015.22 All patients were given the European Organization for Research and Treatment of Cancer quality of life assessment; there was a significant link between low European Organization for Research and Treatment of Cancer scores and the patient’s risk of developing severe toxicity. However, no significant association between variants in methylenetetrahydrofolate reductase (MTHFR) or TYMS tandem repeats and severe toxicity could be identified.

Nahid et al (2017) prospectively evaluated 161 patients with CRC who were treated with 5-FU-based chemotherapy.22 Of these patients, clinical follow-up was available for 139 patients. Within this population, DPYD*2A was significantly associated with grade 3 or 4 toxicity (p=0.023). The MTHFR C6777T variant was associated with increased efficacy of treatment (p=0.006). The authors recommended confirmation of these findings in a larger population.

**Efficacy**

A meta-analysis by Wang et al (2013) included 11 studies that assessed the association between TYMS variants (5¢ tandem repeats and a single nucleotide substitution [G>C] within triplet repeats) and survival outcomes.23 Patients had gastric cancer or CRC and received 5-FU with or without leucovorin with or without levamisole. Three studies (n=311 patients) were eligible for pooled analysis of overall survival (OS). Statistical heterogeneity was not assessed. Patients who were homozygous for triplet repeats (3R/3R) had longer OS than patients who were homozygous for doublet repeats (2R/2R) or compound heterozygous (2R/3R).

Smyth et al (2017) published a randomized phase 3 trial of 456 patients treated for gastroesophageal cancer either with surgery alone or with surgery augmented with 5-FU chemotherapy.24 Of these patients, genetic tests were performed for 289 patients. The primary outcome was any association between ten germline variants, including tandem repeats in the TYMS gene, and response rates, survival, or toxicity. Of the genes evaluated, none showed a variant significantly associated with chemotherapy-related toxicity. Of patients who received chemotherapy, there was a significant association between the TYMS 2R/2R genotype and longer survival: for these patients, median OS was not reached during the study, while patients with TYMS 2R/3R or 3R/3R genotypes, respectively, had a median OS of 1.44 or 1.60 years (p=0.005). Trialists noted that patients with TYMS 2R/2R genotype seemed to benefit from the chemotherapy treatment, with a significant interaction between treatment arm and genotype (p=0.029). No relationship between genotype and chemotherapy toxicity was noted. The trial was limited by the lack of tissue samples for all patients.

**Section Summary: Clinically Valid**

A number of observational studies and meta-analyses of these studies have found that DPYD variants and/or TYMS single nucleotide variants correlated significantly with an increased risk of 5-FU-related toxicity. A meta-analysis of three studies found a significant association between...
TYMS gene variants and longer OS. In a separate study, a different variant of TYMS was significantly associated with longer OS. The available studies reported statistical associations and did not prospectively evaluate health outcomes in patients with genetic variants.

**Clinically Useful**
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

**Direct Evidence**
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

A Blue Cross Blue Shield Association Technology Evaluation Center (TEC) Assessment (2010) concluded that DPYD and TYMS variant testing did not meet TEC criteria.25, The Assessment noted that the tests had “poor ability to identify patients likely to experience severe 5-FU toxicity. Although genotyping may identify a small fraction of patients for whom serious toxicity is a moderate to a strong risk factor, most patients who develop serious toxicity do not have variants in DPD or TS genes.”25.

Several recent prospective observational studies have reported safety and effectiveness outcomes in patients who received genetic testing prior to receiving a 5-FU-based chemotherapy regimen. Characteristics and results of these studies are shown in Tables 2 and 3. Three of these, conducted by the same research group in the Netherlands, used historical controls,26,27,28, and one also included a matched-pairs analysis using previously-collected data.27. The others were single-arm, uncontrolled studies.29,30,31. No prospective trials comparing efficacy and safety outcomes using concurrent control groups with or without pretreatment DPYD and/or TYMS testing were identified.

Henricks et al (2019) included 3 comparison groups in a prospective cohort study in which patients received genotyping prior to treatment as part of routine care.27. Group 1 (n=40) were DPYD*2A carriers treated with an approximately 50% reduced fluoropyrimidine dose. Group 2 (n=1606) were wild-type patients who had been identified as part of an earlier study (Deenan et al [2016];26, discussed below) and treated with a standard dose. Group 3 (n=86) were DPYD*2A carriers, identified from the literature, treated with a standard dose. Safety outcomes of the first 18 of the 40 patients in Group 1 were previously reported in Deenan et al (2016).26. Patients in Group 1 were matched to those in Group 2 for the primary analysis for covariables known to influence treatment outcome. The primary effectiveness endpoint was OS. Secondary endpoints were progression-free survival and tumor response.

In matched-pair comparisons, Groups 1 and 2 did not differ on OS (hazard ratio 0.82; 95% CI 0.47 to 1.43; P=0.47), progression-free survival (hazard ratio 0.83; 95% CI 0.47 to 1.50; p=0.54), or tumor response (0% vs 5% complete response; 20% vs 34% partial response; p>0.99), suggesting that the lower dose did not have a detrimental effect on treatment response in DPYD*2A carriers. The incidence of treatment-related toxicity, including overall toxicity, gastrointestinal toxicity, hematological toxicity, and hand-foot syndrome, was higher in the genotype-guided dosing group compared to wild-type patients, but differences were not statistically significant. Compared to the historical literature cohort who had received standard dosing, Group 1 patients had a lower risk of severe toxicity (77% vs 18% P<0.001). There were no treatment-related deaths in the genotype-guided group, compared to 7 of 86 (8%) in the historical cohort. This study had several methodological limitations. Although patients were prospectively genotyped, data collection of outcomes was retrospective. A historical control group was used for the assessment of adverse events. There was a relatively large amount of missing data, small
sample size, and the study was underpowered. Because it was conducted at a single-institution, its results may not be generalizable to other settings.

Deenan et al (2016) compared outcomes for pretreatment DPYD*2A testing with historical controls. The study included cancer patients intending to undergo treatment with fluoropyrimidine-based therapy (5-FU or capecitabine). Genotyping for DPYD*2A was performed before treatment, and dosing was adjusted based on the alleles identified. Patients with heterozygous variant alleles were treated with a reduced (i.e., ≥50%) starting dose of fluoropyrimidine for 2 cycles, and dosage was then individualized based on tolerability. No homozygous variant allele carriers were identified. Safety outcomes were compared with historical controls. Twenty-two (1.1%) of 2038 patients were heterozygous for DPYD*2A. Eighteen (82%) of these 22 patients were treated with reduced doses of capecitabine. Five (23%; 95% CI, 10% to 53%) patients experienced grade 3 or higher toxicity. In historical controls with DPYD*2A variant alleles, the rate of grade 3 or higher toxicity was 73% (95% CI, 58% to 85%). The historical controls were more likely to be treated with 5-FU-based therapy than with capecitabine-based therapy. Trial limitations included lack of randomization to a management strategy and use of historical, rather than concurrent, controls.

Henricks et al (2018) conducted a prospective study of adult patients with cancer who were intended to start fluoropyrimidine-based therapy. Patients were enrolled from 17 hospitals in the Netherlands. Dose reductions were based on genotyping: Heterozygous DPYD variant allele carriers received an initial dose reduction of either 25% (for c.2846A>T and c.1236G>A) or 50% (for DPYD*2A and c.1679T>G). The researchers compared adverse events in the prospectively genotyped group who received genotype-based dosing, wild-type patients identified through prospective genotyping, and a historical control group of patients from a previously published meta-analysis who were DPYD variant carriers but did not receive genotype-guided dosing. The primary outcome was the frequency of severe treatment-related toxicity. Survival and response were not assessed. There was a higher incidence of grade 3 or higher toxicity in the genotype-dosing group compared to wild-type patients (39% vs 23%; p=0.0013). The relative risk for severe toxicity in DPYD*2A carriers who did not have genotype-guided dosing was 2.87 (95% CI 2.14 to 3.86), compared to 1.31 (0.63 to 2.73) in the cohort that received genotype-based dosing. The main limitation of this study is its use of a historical control group, with no control for confounders in the analysis.

Cremolini et al (2018) reported chemotherapy-related adverse events experienced by patients with metastatic colon cancer who were enrolled in the phase III RCT and treated with first-line FOLFOXIRI plus bevacizumab or FOLFIRI plus bevacizumab. Of 508 randomized patients, 443 (87%) were genotyped for DPYD and UGT1A1 variants. All received study treatments as planned; dosage was not adjusted based on genotyping. All patients received study treatments at planned doses. Overall, eight of ten patients who were DPYD carriers experienced grade 3 or higher adverse events. An advantage of this study was that it used prospectively and systematically collected data on adverse events. It is limited by the lack of a comparison group and because genotype-based dosing was not used.

Goff et al (2014) prospectively genotyped 42 adults who had gastric or gastroesophageal junction cancer for TSER tandem repeats. Twenty-five patients who had TSER 2R/2R or 2R/3R genotypes received a modified 5-FU chemotherapy regimen until unacceptable toxicity or disease progression (median, 5.5 cycles); patients homozygous for triplet repeats (3R/3R) were excluded. The overall response rate in 23 evaluable patients was 39% (9 partial responses, no complete responses), which was worse than a 43% historical overall response rate in unselected patients. The overall response rate in 6 patients homozygous for doublet repeats (2R/2R) was 83% (5 partial responses, no complete responses). Median OS and progression-free survival in the entire cohort (secondary outcomes) was 11.3 months and 6.2 months, respectively; these rates were similar to those reported in unselected populations. The study was stopped before meeting target enrollment (minimum 75 patients) due to insufficient funding.
Magnani et al (2013) reported on 180 cancer patients receiving fluoropyrimidines (5-FU or capecitabine) who underwent DPYD analysis for the 1905+1 G>A variant by high-performance liquid chromatography. Four patients were heterozygous carriers. Of these, 3 patients received a dose reduction of 50% to 60% but still experienced severe toxicities requiring hospitalization. One patient did not receive chemotherapy based on DPYD genotype and the presence of other variants found in mismatch repair genes.

### Table 2. Summary of Key Nonrandomized Trials Characteristics

<table>
<thead>
<tr>
<th>Study</th>
<th>Study Type</th>
<th>Country</th>
<th>Dates</th>
<th>Participants</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Henricks (2019)27</td>
<td>Prospective screening, retrospective data collection, historical control groups</td>
<td>Netherlands</td>
<td>2007-2015</td>
<td>Patients intended to be treated with FU-based chemotherapy (n=1732)</td>
<td>Genotyping for DPYD*2A</td>
</tr>
<tr>
<td>Henricks (2018)28</td>
<td>Prospective, with historical control</td>
<td>Netherlands</td>
<td>2015-2017</td>
<td>Patients intended to be treated with FU-based chemotherapy (n=1181)</td>
<td>Genotyping for DPYD*2A</td>
</tr>
<tr>
<td>Cremolini (2018)31</td>
<td>Prospective, uncontrolled</td>
<td>Italy</td>
<td>2008-2011</td>
<td>Patients with metastatic colorectal cancer who were treated with 5-FU and irinotecan-based chemotherapy in an RCT (n=443)</td>
<td>Genotyping for DPYD*2A</td>
</tr>
<tr>
<td>Deenen (2016)26</td>
<td>Prospective, with historical control</td>
<td>Netherlands</td>
<td>2007-2011</td>
<td>Patients intended to be treated with FU-based chemotherapy (n=2038)</td>
<td>Genotyping for DPYD*2A</td>
</tr>
<tr>
<td>Goff (2014)29</td>
<td>Prospective, uncontrolled</td>
<td>US</td>
<td>2008-2010</td>
<td>Adults with gastric or gastroesophageal junction cancer (n=25)</td>
<td>Genotyping for TSER tandem repeats</td>
</tr>
<tr>
<td>Magnani (2013)30</td>
<td>Prospective, uncontrolled</td>
<td>Italy</td>
<td>2011-2012</td>
<td>Patients diagnosed with gastrointestinal, breast, head and neck, and other tumors (n=180)</td>
<td>DPYD analysis</td>
</tr>
</tbody>
</table>

FU: fluoropyrimidine

### Table 3. Summary of Key Nonrandomized Trials Results

<table>
<thead>
<tr>
<th>Study</th>
<th>Heterozygous Carrier Patients</th>
<th>Grade 3 Toxicity</th>
<th>Overall Response Rate</th>
<th>Median Overall Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>Henricks (2019)27</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 1: DPYD*2A carriers, reduced dose (n=40)</td>
<td>40</td>
<td>7/40 (18%)</td>
<td>0% complete response, 20% partial response, 40% stable</td>
<td>27 months (range 1-83 months)</td>
</tr>
<tr>
<td>Group 2: Wild-type, standard dose (n=1606)</td>
<td>NA</td>
<td>372/1606 (23%)</td>
<td>5% complete response, 29% partial response, 14% stable</td>
<td>24 months (range 0.7 to 97 months)</td>
</tr>
<tr>
<td>Group 3: DPYD*2A carriers, standard dose (n=86)</td>
<td>86</td>
<td>66/86 (77%)</td>
<td>NR</td>
<td></td>
</tr>
<tr>
<td>Hazard ratio (95%CI)</td>
<td>Group 1 vs Group 2: 0.82 (0.47 to 1.43)</td>
<td>Group 1 vs Group 2: 0.47</td>
<td>Group 1 vs Group 2: &gt;0.99</td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>Group 1 vs Group 2: 0.57</td>
<td>Group 1 vs group 3: &lt;0.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Henricks (2018)28</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DPYD*2A carriers, genotype-guided dosing</td>
<td>85/1181 (7.7%)</td>
<td>33/85 (39%)</td>
<td>RR 1.31 (95% CI 0.63 to 2.73)</td>
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</tr>
<tr>
<td>Historical control (DPYD*2A carriers, standard dose)</td>
<td>RR 2.87 (95% CI 2.14 to 3.86)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4. Relevance Limitations

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Intervention</th>
<th>Comparator</th>
<th>Outcomes</th>
<th>Duration of Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Henricks (2019)27.</td>
<td>27, historical control group</td>
<td>no effectiveness outcomes</td>
<td>1. no effectiveness outcomes</td>
<td>11.3 months; 6.2 months</td>
<td></td>
</tr>
<tr>
<td>Henricks (2018)28.</td>
<td>28, historical control group</td>
<td>no effectiveness outcomes</td>
<td>1. no effectiveness outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cremolini (2018)31.</td>
<td>3. genotype-based dosing not used</td>
<td>no control group</td>
<td>1. no effectiveness outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deenen (2016)26.</td>
<td>historical control group</td>
<td>1. no effectiveness outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goff (2014)29.</td>
<td>no control group</td>
<td>1. no effectiveness outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Magnani (2013)30.</td>
<td>no control group</td>
<td>1. no effectiveness outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The study limitations stated in this table are those notable in the current review; this is not a comprehensive limitations assessment.

The purpose of the limitations tables (see Tables 4 and 5) is to display notable limitations identified in each study.

Table 5. Study Design and Conduct Limitations

<table>
<thead>
<tr>
<th>Study</th>
<th>Selection</th>
<th>Blinding</th>
<th>Delivery of Test</th>
<th>Selective Reporting</th>
<th>Data Completeness</th>
<th>Statistical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Henricks (2019)27.</td>
<td>2 not randomized</td>
<td>1 not blinded</td>
<td></td>
<td></td>
<td>2, 3</td>
<td></td>
</tr>
<tr>
<td>Henricks (2018)28.</td>
<td>2 not randomized</td>
<td>1 not blinded</td>
<td></td>
<td></td>
<td>2, 3</td>
<td></td>
</tr>
<tr>
<td>Cremolini (2018)31.</td>
<td>2. convenience sample</td>
<td>1 not blinded</td>
<td></td>
<td></td>
<td>2, 3</td>
<td></td>
</tr>
<tr>
<td>Deenen (2016)26.</td>
<td>2 not randomized</td>
<td>1 not blinded</td>
<td></td>
<td></td>
<td>2, 3</td>
<td></td>
</tr>
</tbody>
</table>
Laboratory and Genetic Testing for Use of 5-Fluorouracil in Patients With Cancer

<table>
<thead>
<tr>
<th>Study</th>
<th>Selection</th>
<th>Blinding</th>
<th>Delivery of Test</th>
<th>Selective Reporting</th>
<th>Data Completeness</th>
<th>Statistical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goff (2014)29</td>
<td>2 sample</td>
<td>1 not</td>
<td>2, 3</td>
<td>2 no comparator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Magnani (2013)30</td>
<td>2 sample</td>
<td>1 not</td>
<td>2, 3</td>
<td>2 no comparator</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The study limitations stated in this table are those notable in the current review; this is not a comprehensive limitations assessment.

- **Selection key**: 1. Selection not described; 2. Selection not random or consecutive (i.e., convenience).
- **Blinding key**: 1. Not blinded to results of reference or other comparator tests.
- **Delivery key**: 1. Timing of delivery of index or reference test not described; 2. Timing of index and comparator tests not same; 3. Procedure for interpreting tests not described; 4. Expertise of evaluators not described.
- **Selective Reporting key**: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.
- **Data Completeness key**: 1. Inadequate description of indeterminate and missing samples; 2. High number of samples excluded; 3. High loss to follow-up or missing data.
- **Statistical key**: 1. Confidence intervals and/or p values not reported; 2. Comparison with other tests not reported.

**Section Summary: Clinically Useful**

A TEC Assessment (2010) concluded that DPYD and TYMS variant testing had a poor ability to identify patients likely to experience severe 5-FU toxicity. Since the publication of the TEC Assessment, no prospective trials comparing the efficacy and toxicity outcomes in patients who did and did not undergo pretreatment DPYD and/or TYMS testing have been published. Three prospective observational studies used a historical control group and one also used a matched-pairs analysis to compare outcomes in patients who received genotype-based dosing to those who received standard dosing. No differences in OS, progression-free survival, or tumor progression were observed. Risk of serious toxicity was higher in DPYD allele carriers who received genotype-based dosing compared to wild-type patients but lower when compared to historical controls who were carriers but received standard dosing. The evidence is limited by retrospective data collection, use of historical control groups, small sample sizes, and missing data.

**Summary of Evidence**

For individuals who have cancer for whom treatment with 5-FU is indicated who receive laboratory assays to determine 5-FU AUC, the evidence includes RCTs, observational studies, and systematic reviews. The relevant outcomes are OS, disease-specific survival, test accuracy and validity, and treatment-related morbidity. Several analyses of patients with CRC have evaluated clinical validity. One study, for example, found the rate of severe toxicity was significantly lower in patients with stage II and III cancer who chose pharmacokinetic monitoring vs BSA monitoring but progression-free survival did not differ between groups in patients with stage IV or recurrent cancer. No RCTs or nonrandomized comparative studies were identified comparing health outcomes in cancer patients who did and did not have 5-FU dose adjustment using the My5-FU assay and who were treated with chemotherapy regimens used in current clinical practice. A systematic review of the available literature found a significantly higher response rate with BSA-based monitoring and no significant difference in toxicity. Most data derived from observational studies and the RCTs were conducted in the 1980s when different chemotherapy protocols were used. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have cancer for whom treatment with 5-FU is indicated who receive genetic testing for variants (e.g., in DPYD and TYMS) affecting 5-FU metabolism, the evidence includes observational studies and systematic reviews. The relevant outcomes are OS, disease-specific survival, test accuracy and validity, and treatment-related morbidity. A TEC Assessment (2010) concluded that DPYD and TYMS variant testing had poor prognostic capacity to identify patients likely to experience severe 5-FU toxicity. Since the publication of that Assessment, no prospective trials comparing the efficacy and toxicity outcomes in patients who did and did not
undergo pretreatment DPYD and/or TYMS testing have been published. Three prospective observational studies used a historical control group and one also used a matched-pairs analysis to compare outcomes in patients who received genotype-based dosing to those who received standard dosing. No differences in OS, progression-free survival, or tumor progression were observed. Risk of serious toxicity was higher in DPYD allele carriers who received genotype-based dosing compared to wild-type patients but lower when compared to historical controls who were carriers but received standard dosing. The evidence is limited by retrospective data collection, use of historical control groups, small sample sizes, and missing data. The evidence is insufficient to determine the effects of the technology on health outcomes.

Supplemental Information
Practice Guidelines and Position Statements

National Comprehensive Cancer Network Guidelines
Although current National Comprehensive Cancer Network guidelines acknowledge that the “selection, dosing, and administration of anticancer agents and the management of associated toxicities are complex,” the Network does not recommend use of area under the curve guidance for 5-fluorouracil (5-FU) dosing or genetic testing for DPYD and/or TYMS variants in patients with colon, rectal, breast, gastric, pancreatic cancer, or head and neck cancers.

Clinical Pharmacogenetics Implementation Consortium
The CPIC (2009) was formed as a shared project between PharmGKB, an internet research tool developed by Stanford University, and the Pharmacogenomics Research Network of the National Institutes of Health. The CPIC (2013) published evidence-based guidelines for DPYD genotype and fluoropyrimidine dosing. The guidelines did not address testing.

An update to the CPIC (2017) guidelines was published by Amstutz et al (2018). As in 2013, the primary focus of the guidelines was on the DPYD genotype and implications for dosing of fluoropyrimidine. In the update, the CPIC (2017) noted that genetic testing for DPYD may include “resequencing of the complete coding regions” or may be confined to analysis of particular risk variants, among which CPIC listed the c.190511G>A, c.1679T>G, c.2846A>T, and c.1129-5923C>G variants, as affecting 5-FU toxicity. The guideline further noted that, while other genes (TYMS, MTHFR) may be tested for variants, the clinical utility of such tests is yet unproven. In patients who have undergone genetic testing and who are known carriers of a DPYD risk variant, the guidelines recommended that caregivers strongly reduce the dosage of 5-FU-based treatments, or exclude them, depending on the patient’s level of DPYD activity. CPIC advised follow-up therapeutic drug monitoring to guard against underdosing and cautioned that genetic tests could be limited to known risk variants and, therefore, not identify other DPYD variants.

National Institute for Health and Care Excellence
The National Institute of Health and Care Excellence (2014) published evidence-based diagnostics guidance on the 5-FU assay for 5-FU chemotherapy dose adjustment. The guidance stated: “The MyS-FU assay is only recommended for use in research for guiding dose adjustment in people having fluorouracil chemotherapy by continuous infusion. The MyS-FU assay shows promise and the development of robust evidence is recommended to demonstrate its utility in clinical practice.”

U.S. Preventive Services Task Force Recommendations
Not applicable.

Medicare National Coverage
There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.
Ongoing and Unpublished Clinical Trials
Some currently ongoing and unpublished trials that might influence this review are listed in Table 6.

Table 6. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
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</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td>AUC-guided dosing of 5-FU</td>
<td></td>
<td></td>
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<tr>
<td>NCT00943137</td>
<td>The Optimisation of 5-Fluouracil Dose by Pharmacokinetic Monitoring in Asian Patients With Advanced Stage Cancer</td>
<td>55</td>
<td>Jun 2017 (unknown)</td>
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<tr>
<td>NCT02055560</td>
<td>Retrospective Data Comparison of Toxicity and Efficacy in Colorectal Cancer (CRC) Patients Managed With and Without 5-FU Exposure Optimization Testing</td>
<td>350</td>
<td>Dec 2017 (unknown)</td>
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<tr>
<td>DPYD and/or TYMS testing before use of fluoropyrimidines</td>
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<td></td>
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<tr>
<td>NCT02324452</td>
<td>Safety, Feasibility and Cost-effectiveness of Genotype-directed Individualized Dosing of Fluoropyrimidines</td>
<td>1250</td>
<td>Mar 2018 (ongoing)</td>
</tr>
<tr>
<td>NCT00131599</td>
<td>Thymidylate Synthase Polymorphisms as a Predictor of Toxicity to 5-Fluorouracil Based Chemotherapy in Stage III Colon C</td>
<td>104</td>
<td>July 2017 (ongoing)</td>
</tr>
<tr>
<td>NCT02138617</td>
<td>Genotype-Directed Phase II Study Of Higher Dose Of Irinotecan In First-Line Metastatic Colorectal Cancer Patients Treated With Folfiri Plus Bevacizumab</td>
<td>100</td>
<td>May 2022</td>
</tr>
</tbody>
</table>

AUC: area under the curve; 5-FU: 5-Fluorouracil; NCT: national clinical trial.
a Denotes industry-sponsored or cosponsored trial.

References


25. Blue Cross and Blue Shield Association Technology Evaluation Center (TEC). Pharmacogenetic Testing to Predict Serious Toxicity From 5-Fluorouracil (5-FU) for Patients Administered 5-FU-Based Chemotherapy for Cancer. TEC Assessments. 2010;24:Tab 13.


Documentation for Clinical Review

- No records required

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.

IE

The following services may be considered investigational.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT®</td>
<td>81230</td>
<td>CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (e.g., drug metabolism), gene analysis, common variant(s) (e.g., *2, *22)</td>
</tr>
<tr>
<td></td>
<td>81231</td>
<td>CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (e.g., drug metabolism), gene analysis, common variants (e.g., *2, *3, *4, *5, *6, *7)</td>
</tr>
<tr>
<td></td>
<td>81232</td>
<td>DPYD (dihydropyrimidine dehydrogenase) (e.g., 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (e.g., *2A, *4, *5, *6)</td>
</tr>
<tr>
<td></td>
<td>81346</td>
<td>TYMS (thymidylate synthetase) (e.g., 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (e.g., tandem repeat variant)</td>
</tr>
<tr>
<td>HCPCS</td>
<td>S3722</td>
<td>Dose optimization by area under the curve (AUC) analysis, for infusional 5-fluorouracil</td>
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<tr>
<td>ICD-10 Procedure</td>
<td>None</td>
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</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>
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<tbody>
<tr>
<td>07/30/2015</td>
<td>BCBSA Medical Policy adoption</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>06/01/2016</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>05/01/2017</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
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<tr>
<td>02/01/2018</td>
<td>Coding update</td>
<td>Administrative Review</td>
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<td>05/01/2018</td>
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<td>Medical Policy Committee</td>
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<tr>
<td>05/01/2019</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
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<td>10/01/2019</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
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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 be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at 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.