Clinical Review Criteria
Extracorporeal Photopheresis

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Criteria
For Medicare Members

<table>
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<th>Source</th>
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<tr>
<td>CMS Coverage Manuals</td>
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<tr>
<td>National Coverage Determinations (NCD)</td>
<td>Extracorporeal Photopheresis (110.4)</td>
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<td>Local Coverage Determinations (LCD)</td>
<td>None</td>
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<td>Local Coverage Article</td>
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For Non-Medicare Members
Extracorporeal Photopheresis for Acute and Chronic Graft vs. Host
Medical necessity review no longer required for this service.

Extracorporeal Photopheresis for Cutaneous T-Cell Lymphoma (CTCL)
Must meet ALL of the following:
A. The extracorporeal device must be FDA approved;
B. The patient has cutaneous t-cell lymphoma that has not responded to other forms of treatment;
C. The use is for palliative treatment of associated skin manifestations.

The following information was used in the development of this document and is provided as background only. It is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background
Extracorporeal photopheresis (ECP) is a treatment modality for graft-versus-host disease (GVHD) and cutaneous t-cell lymphoma (CTCL). CTCL refers to several clonal t-cell malignancies that primarily manifest as skin conditions. GVHD is a complication of allogenic stem cell transplantation.

Extracorporeal photopheresis is one of the treatment options for refractory acute and chronic GVHD. ECP involves removing the patient’s peripheral blood and separating it into leukocyte-depleted blood and leukocyte-enriched plasma. The leukocyte-depleted blood is returned to the patient. The leukocyte-enriched plasma is exposed to ultraviolet light in the presence of an extracorporeally administered photosensitizing agent, 8-methoxypsoralen (8-MOP). The cells are then re-infused into the patient and die in one-week period. During that week, they are capable of stimulating an anti-idiotypic t suppressor response. The exact mechanism of action of ECP is not known. The Therakos Photopheresis System is FDA approved as a class III medical device specifically for photopheresis (Greinix et al., 2000; Woltz et al., 2006).

There are no agreed-upon standards for the optimal frequency and duration for ECP treatment in patients with chronic GVHD, and there is wide variability in practice. Patients may be treated two or three days a week every two to three weeks for 3 to 30 months (Woltz et al., 2006).

Extracorporeal photopheresis (ECP) is also a treatment option for CTCL. ECP involves removing a portion of the patient’s blood and separating into red and white blood cells by centrifugation. The red cells are returned to the patient. The white cells are mixed with a photosensitizing agent, 8-methoxypsoralen or methoxsalen (Uvadex,
Extracorporeal Photopheresis in the Treatment of Acute and Chronic Graft vs. Host Disease

The FDA has approved the photopheresis device UVAR and the photosensitizing Uvadex (both by Therakos) for the palliative treatment of skin manifestations of cutaneous T-cell lymphoma that has not responded to other forms of treatment. ECP is covered by Medicare for the same indication.

Evidence and Source Documents
Extracorporeal Photopheresis for Acute and Chronic Graft vs. Host Disease
Extracorporeal Photopheresis for Cutaneous T-Cell Lymphoma (CTCL)

Medical Technology Assessment Committee (MTAC)
Extracorporeal Photopheresis in the Treatment of Acute and Chronic Graft Versus Host Disease

BACKGROUND
Graft-versus-host disease (GVHD) is a complication of allogenic stem cell transplantation (SCT). There are two forms of GVHD, acute and chronic. Acute GVHD occurs within the first 100 days of transplantation. In acute GVHD, the T-lymphocytes from the donor recognize tissues or cells in the recipient as foreign and produce a multi-organ (i.e. skin, liver, intestines) autoimmune-like syndrome. The T-lymphocytes use information from genetic markers known as human leukocyte antigens (HLA) to detect differences. Even when donors are matched for HLA markers, GVHD can occur because minor differences in these markers could still exist. Efforts to prevent acute GVHD include using closely matched donors, umbilical cord blood and/or post transplant immunosuppression with drugs including cyclosporine and methotrexate. Acute GVHD is commonly treated with corticosteroids which produce sustained responses in 50-80% of patients depending on the initial severity of disease. Second-line therapy includes different combinations of immunosuppressive agents. Newer treatments include infusion of mesenchymal stem cells (MSC), down-regulation of antigen-presenting cells (APC) and suicide gene transduced T cells (Bacigalupo, 2007). Chronic GVHD can occur after the first 100 days post-transplant, either in patients who experienced acute GVHD or a de novo onset. It is the main cause of late morbidity and mortality after allogenic SCT. Chronic GVHD generally involves donor T cells expanding and attacking the host's immunologic system; its pathophysiology is poorly understood compared to acute GVHD (Woltz et al., 2006; PerezSimon et al., 2006). Standard first-line treatment for chronic GVHD includes prednisone alone or in combination with a calcineurin inhibitor such as cyclosporin or tacrolimus. A recent review article (Perez-Simon et al., 2006) states that there is no generally accepted salvage treatment for patients with chronic GVHD who do not respond to prednisone. Treatments that have been used for refractory chronic GVHD include mycophenolate mofetil, anti-interleukin-2a receptor antagonists, sirolimus, pentostatin, CD20 antagonists, tumor necrosis factor-a antagonists and extracorporeal photopheresis. Other, newer treatments include anti-CD25 immunotoxin and inhibition of nuclear factor-db. The authors of the review article recommend that chronic GVHD patients enter clinical trials for salvage treatment if at all possible. Extracorporeal photopheresis (ECP) is one of the treatment options for refractory acute and chronic GVHD. ECP involves removing the patient's peripheral blood and separating it into leukocyte-depleted blood and leukocyte-enriched plasma. The leukocyte-depleted blood is returned to the patient. The leukocyte-enriched plasma is exposed to ultraviolet light in the presence of an extracorporally administered photosensitizing agent, 8-methoxypsoralen (8-MOP). The cells are then re-infused into the patient and die in one-week period. During that week, they are capable of stimulating an antidiotype T suppressor response. The exact mechanism of action of ECP is not known. The Therakos Photopheresis System is FDA approved as a class III medical device specifically for photopheresis (Greinix et al., 2000; Woltz et al., 2006). There is no generally agreed-upon standards for the optimal frequency and duration for ECP treatment in patients with chronic GVHD, and there is wide variability in practice. Patients may be treated two or three days a week every two to three weeks for 3 to 30 months (Woltz et al., 2006). ECP for acute and chronic graft versus host disease was first reviewed by MTAC in 2002. At that time, the empirical evidence consisted of small case series, with sample sizes varying from 3 to 23. The item failed MTAC evaluation criteria, and the Health Plan
Extracorporeal Photopheresis in the Treatment of Acute and Chronic Graft Versus Host Disease

Evidence Conclusion: There is not enough evidence to permit conclusions on the effectiveness of extracorporeal photopheresis for treating acute or chronic graft-versus-host disease.

Articles: The search yielded 16 articles. There were no randomized controlled trials. Seven of the articles were reviews or editorials, two were case reports and seven were small case series (varying in size from n=3 to n=23). Due to the low grade of evidence and the small size of the studies, no evidence tables were created.

The use of extracorporeal photopheresis in the treatment of acute and chronic graft versus host disease does not meet the Kaiser Permanente Medical Technology Assessment Criteria.

Extracorporeal Photopheresis for Cutaneous T-Cell Lymphoma (CTCL)

BACKGROUND
Cutaneous T-cell lymphoma (CTCL) refers to several clonal T-cell malignancies that primarily manifest as skin conditions. The classical subsets of CTCL include mycosis fungoides (MF), the most common form, and Sezary Syndrome (SS). MF usually presents as chronic eczematous or psoriasiform patches or plaques whereas SS is characterized by erythroderma and leukemia. SS is sometimes viewed as an advanced form of MF. According to

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Extracorporeal photopheresis for cutaneous T-cell lymphoma (CTCL) has been shown to be clearly superior to the others. Disadvantages of systemic chemotherapeutic agents are that they have immunosuppressive effects which can lead to opportunistic infections, sepsis or death (Apisarnthanarax et al., 2002). Extracorporeal photopheresis (ECP) is another treatment option for CTCL. ECP involves removing a portion of the patient’s blood and separating into red and white blood cells by centrifugation. The red cells are returned to the patient. The white cells are mixed with a photosensitizing agent, 8-methoxypsoralen or methoxsalen (Uvadex, Therakos), and irradiated with ultraviolet light (UVA light, 320-400 nm). When activated, the photosensitizing agent binds with the cellular DNA of the white cells and accelerates their death. The altered cells are then reinfused into the patient. The intention is that these cells will stimulate an immune response against the damaged pathogenic T cell clones. In the pivotal study upon which FDA approval was based, a case series with 37 patients by Edelson and colleagues, a greater treatment effect was seen in patients with erythrodermic CTCL (later-stage disease) compared to those with plaques or tumors. This distinction has been difficult to confirm in later case series because studies generally include patients at different stages of clinical disease and do not report findings separately by disease stage. The effectiveness of ECP for treating CTCL, particularly the following information was used in the development of this document and is provided as background only. Sezary Syndrome continues to be debated in the literature. Some of the controversies are whether prior treatment with systemic corticosteroids and systemic chemotherapy reduces the effectiveness of ECP and which sub-groups of patients are most likely to benefit from ECP treatment. To date, there have not been any randomized controlled trials comparing ECP to other treatments for CTCL (Apisarnthanarax et al., 2002; Russell-Jones, 2000; FDA website; Therakos website). The FDA has approved the photopheresis device UVAR and the photosensitizing Uvadex (both by Therakos) for the palliative treatment of skin manifestations of cutaneous T-cell lymphoma that has not responded to other forms of treatment. ECP is covered by Medicare for the same indication. Extracorporeal photopheresis for CTCL has not been reviewed previously by MTAC. ECP for the treatment of graft versus host disease was reviewed by MTAC in June, 2002.

06/05/2006: MTAC REVIEW

Extracorporeal Photopheresis for Cutaneous T-Cell Lymphoma (CTCL)

Evidence Conclusion: There are no randomized controlled trials evaluating the efficacy of extracorporeal photopheresis for treating patients with CTCL. The published literature consists of small, predominantly retrospective case series. The ECP treatment protocol was similar in the case series that were reviewed, generally consisting of treatment every 4 weeks with a tapering off by lengthening treatment intervals in patients who achieved a response. Data from case series suggests that ECP might be helpful for treating skin manifestations of CTCL, the FDA approved indication. However, there are no data on the efficacy of ECP for skin conditions compared to an alternative treatment or no treatment. In the single prospective study, 27/37 patients had a positive response to treatment, defined as at least a 25% reduction in the skin score. 24/29 patients with erythroderma had a positive response after a mean follow-up of 42 weeks (Edelson et al., 1987). A study published 5 years later on the 29 patients with erythroderma (Heald et al., 1992) found that most of the patients had at least some improvement in skin manifestations of CTCL and 6 had a complete remission. It is not possible to draw conclusions about survival after ECP treatment due to the lack of comparative data from RCTs. Predicted median survival using life-table analysis in the Heald/Edelson study was 60 months from time of diagnosis of the erythrodermic state. One of the case series (Fraser-Andrews et al. 1998) included a non-randomized comparison group of patients who did not receive ECP treatment. They did not find a statistically significant difference in median length of survival from time of SS diagnosis in the two groups (39 months in ECP-treated patients vs. 26.5 months in non-EC treated patients, p=0.12). Other than a lack of randomization, limitations of the Fraser-Andrews study was the wide variety of other treatments patients received before, during and after ECP treatment, or instead of ECP treatment. It is difficult to attribute a response to the ECP treatment itself. The limited data on use of ECP for CTCL identified few adverse effects.

Articles: No randomized controlled trials were identified. The empirical studies were all case series, each with a sample size of less than 50. Desirable features of case series were prospective design, larger sample size, clear eligibility criteria, longer follow-up and survival included as an outcome. Three studies included survival as an outcome in addition to treatment response; had sample sizes n>25 and had reasonably long-term follow-up; however, only one of them was prospective. These three studies were critically appraised. The prospective study reporting on patient survival was the original Edelson (1987) study, with follow-up data reported by Heald and colleagues in 1992. Excluded studies include a prospective study that included only 14 patients and a small...

The use of extracorporeal photopheresis in the palliative treatment of cutaneous T-cell lymphoma lesions does not meet the Kaiser Permanente Medical Technology Assessment Criteria.

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MDCRPC Medical Director Clinical Review and Policy Committee
MPC Medical Policy Committee

Revision History

Codes
CPT: 36522