

Clinical Policy: Allogenic Hematopoietic Cell Transplants for Sickle Cell Anemia and β -Thalassemia

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Description

This policy describes the medical necessity requirements for allogenic hematopoietic cell transplants for sickle cell anemia and β -thalassemia. Sickle cell anemia and β -thalassemia are two hemoglobinopathies caused by deleterious genetic alterations in hemoglobin. These monogenic diseases present a range of heterogeneous symptoms that stem from damaged red blood cell function. Despite its limitations, allogenic hematopoietic cell transplants are the only curative therapies possible for these hemoglobinopathies.

Policy/Criteria

- I. It is the policy of PA Health & Wellness (PHW) that allogenic hematopoietic cell transplants for sickle cell anemia and homozygous β -thalassemia are **medically necessary** for members when all the following criteria are met:
 - A. *Sickle Cell Anemia*, meets all
 1. Age \leq 45 years;
 2. HLA-matched donor is available;
 3. History of stroke or is at risk of stroke or end-organ damage, as shown by at least one of the following: prior stroke, recurrent chest syndrome, recurrent vaso-occlusive crises, or red blood cell alloimmunization on chronic transfusion therapy;
 - B. *Homozygous β -Thalassemia*
 1. Age \leq 45 years;
 2. HLA-matched donor is available;
 3. Deteriorating with conventional treatments, including transfusions, splenectomy, and treatment with chelating agents (such as deferoxamine or deferiprone);
- II. It is the policy of PHW that the following are considered **experimental/investigational**:
 - A. Autologous hematopoietic cell transplant for sickle cell anemia;
 - B. Autologous hematopoietic cell transplant for β -thalassemia;
 - C. For the treatment of sickle cell anemia or homozygous β -Thalassemia for any other indications than those specified above.

Background

Hemoglobinopathies are a group of over 1,000 hematological disorders that result from deleterious molecular alterations to hemoglobin and are broadly classified into two categories based on the phenotypic characteristics of these variations.¹ The first of these categories includes disorders, such as sickle cell anemia, in which there is a structural defect in one of the globin subunits.¹ Thalassemia belongs to the second category of hemoglobinopathies in which there is a quantitative defect in the production of one or more of the globin subunits.¹

In adults, hemoglobin is a heterotetramer that is comprised of the α - and β -globin subunits.² Each globin subunit forms a stable linkage with heme so that oxygen in the cytosol of an erythrocyte can bind reversibly to heme's iron atoms.² The hemoglobin tetramer $\alpha_2\beta_2$ binds and unloads

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oxygen in a cooperative manner, which maximizes the transport of oxygen to cells.² Additional gas transport functions of hemoglobin include the transport of carbon dioxide and nitric oxide.³ Each of these physiological aspects of hemoglobin are deleteriously affected in the hemoglobinopathy disorders.

Sickle Cell Anemia and β -Thalassemia

Sickle cell disease results from a synonymous mutation that exchanges glutamic acid with valine at position 6 in the β -globin subunit.⁴ Homozygous inheritance of this mutation results in the disease phenotype, whereas heterozygous carriers do not exhibit clinical disease symptoms; heterozygous carriers are also referred to as sickle cell trait.⁴ This amino acid substitution causes deoxygenated hemoglobin to rigid polymers in red blood cells, which ultimately forms the classic sickle-shaped morphology.² The sickle red blood cells occlude the microvasculature which leads to tissue hypoxia, infarction, and chronic hemolytic anemia.⁴ Thus, sickle cell anemia presents a heterogeneous range of clinical manifestations, including pain, strokes, vaso-occlusive episodes, multi-organ injury, reduced quality of life, and shortened lifespan.^{2,4}

Autosomal mutations in the gene encoding the β -globin subunit cause β -thalassemia (also known as thalassemia major or Cooley's anemia).⁵ These mutations inhibit the synthesis of β -globin in erythropoietic cells.^{2,5} The extent of the molecular basis for these mutations is very heterogeneous because over 200 mutations within the β -globin subunit, ranging from synonymous mutations to deletions.¹ Consequently, α -globin molecules form toxic aggregates which destroy erythroid precursors through a process called ineffective erythropoiesis.^{2,5} Also, individuals with β -thalassemia suffer from anemia due to shortened red blood cell survival, hemolysis anemia.⁵

Hematopoietic Cell Transplantation

Hematopoietic cell transplantation (HCT) is recognized as the only cure for sickle cell disease, and the success rate for specific pediatric groups has been shown to be 85 – 90%.⁴ In the United States, it is estimated that the number of children with homozygous sickle cell anemia is 70,000 – 100,000, of which 5,000 – 7,000 could be eligible for transplantation.⁶ A survey of the European Blood and Marrow Transplant and CIBMTR data files that ~1,200 patients in total have received HCT for sickle cell disease, and the 3 year survival rate is ~90% regardless of the source of hematopoietic stem cells.⁶ Furthermore, Lucarelli *et al.* and Angelucci *et al.* both have documented the literature for recent reports on outcomes of HCT from HLA-matched donors in cases of β -thalassemia.^{8,9} Although stem cell sources and the risk categories of the patients vary, overall survival and thalassemia free survival range from approximately 65% - 90% among the numerous reports.^{8,9}

The establishment of complete donor-derived erythropoiesis can stabilize function in affected organs, such as the central nervous system and lungs.⁷ However, HCT related organ toxicities, graft vs host disease, graft rejection, and donor availability are major limitations of this procedure.⁷ Infertility and gonadal failure are two specific morbidities with which HCT is associated.⁴ Also, use of fully matched sibling donors as potentially eligible donors is one of the limitations for HCT implementation.⁴ However, siblings are preferable HCT donors due to the lowered risk of graft vs host disease.⁶

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Other differences between the considerations for HCT for β -thalassemia and sickle cell anemia include key issues for risk factors for transplant-related complications, transplant outcome, and conditioning regimen.⁹ The major risk factors when considering HCT for β -thalassemia include age and organ dysfunction due to iron overload, whereas the major risk factors for HCT due to sickle cell anemia are age and history of cerebral events.⁹ Control of iron overload and related tissue damage presents is a significant consideration for HCT for β -thalassemia, while obtaining a cure from chronic inflammation and prevention of sickle cell related organ damage must be considered for sickle cell anemia.⁹ Lastly, β -thalassemia patients require an ablative conditioning regimen, whereas a reduced intensity regimen seems to induce stable chimerism and full donor erythropoiesis in sickle cell anemia patients.⁹

Coding Implications

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CPT®* Codes	Description
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor

HCPCS Codes	Description
S2150	Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre and post-transplant care in the global definition

ICD-10-CM Code	Description
D56.1	Beta thalassemia
D57	Sickle-cell disorders

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	11/17	11/17
Clarified language in II.C. References reviewed and updated.	02/18 CPC	05/18

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Reviews, Revisions, and Approvals	Date	Approval Date
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References

1. Forget, Bernard G., and H. Franklin Bunn. "Classification of the Disorders of Hemoglobin." *Cold Spring Harbor perspectives in medicine* 3.2 (2013): a011684.
2. Sankaran, Vijay G., and Mitchell J. Weiss. "Anemia: progress in molecular mechanisms and therapies." *Nature medicine* 21.3 (2015): 221-230.
3. Schechter, Alan N. "Hemoglobin research and the origins of molecular medicine." *Blood* 112.10 (2008): 3927-3938.
4. Kanter, Julie, and Rebecca Kruse-Jarres. "Management of sickle cell disease from childhood through adulthood." *Blood reviews* 27.6 (2013): 279-287.
5. Ribeil, Jean-Antoine, et al. "Ineffective erythropoiesis in β -thalassemia." *The Scientific World Journal* 2013 (2013).
6. Gluckman, Eliane. "Allogeneic transplantation strategies including haploidentical transplantation in sickle cell disease." *ASH Education Program Book* 2013.1 (2013): 370-376.
7. Shenoy, Shalini. "Hematopoietic stem-cell transplantation for sickle cell disease: current evidence and opinions." *Therapeutic advances in hematology* 4.5 (2013): 335-344.
8. Lucarelli, Guido, et al. "Hematopoietic stem cell transplantation in thalassemia and sickle cell anemia." *Cold Spring Harbor perspectives in medicine* 2.5 (2012): a011825.
9. Angelucci, Emanuele, et al. "Hematopoietic stem cell transplantation in thalassemia major and sickle cell disease: indications and management recommendations from an international expert panel." *Haematologica* 99.5 (2014): 811-820.
10. Khan, S. Hematopoietic cell transplantation in sickle cell disease. In: UpToDate, Tirnauer JS (Ed), UpToDate, Waltham, MA. (Accessed on February 6, 2018)
11. Hayes Health Technology. Allogeneic Hematopoietic Stem Cell Transplantation for Sickle Cell Disease in Children and Young Adults. Lansdale, PA: Hayes, Inc.; 2014 Winifred S. Hayes, Inc. February 25, 2016. (Accessed on February 8, 2018).
12. Ozdogu H, Boga C, Yeral M, et al. Allogeneic peripheral stem cell transplantation from HLA-matched related donors for adult sickle cell disease: remarkable outcomes from a single-center trial. *Bone Marrow Transplant*. 2018 Feb 5.
13. Gilman AL, Eckrich MJ, Epstein S, et al. Alternative donor hematopoietic stem cell transplantation for sickle cell disease. *Blood Adv*. 2017 Jun 28;1(16):1215-1223.
14. Allen ES, Srivastava K, Hsieh MM, et al. Immunohaematological complications in patients with sickle cell disease after haemopoietic progenitor cell transplantation: a prospective, single-centre, observational study. *Lancet Haematol*. 2017 Nov;4(11):e553-e561