# Coverage Summary

## Chemotherapy, and Associated Drugs and Treatments

<table>
<thead>
<tr>
<th>Policy Number:</th>
<th>C-014</th>
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<tbody>
<tr>
<td>Products:</td>
<td>UnitedHealthcare Medicare Advantage Plans</td>
</tr>
<tr>
<td>Original Approval Date:</td>
<td>12/15/2008</td>
</tr>
<tr>
<td>Approved by:</td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
</tr>
<tr>
<td>Last Review Date:</td>
<td>10/16/2018</td>
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### Related Medicare Advantage Policy Guidelines:

- Anti-Cancer Chemotherapy for Colorectal Cancer (NCD 110.17)
- Anzemet for Chemotherapy Induced Nausea
- Aprepitant for Chemotherapy-Induced Emesis (NCD 110.18)
- Autologous Cellular Immunotherapy Treatment (NCD 110.22)
- Blood Brain Barrier Osmotic Disruption for Treatment of Brain Tumor (NCD 110.20)
- Camptosar™ (Irinotecan)
- Certain Drugs Distributed by the National Cancer Institute (NCD 110.2)
- Eloxatin® (Oxaliplatin)
- Erbitux® (Cetuximab)
- Hyperthermia for Treatment of Cancer (NCD 110.1)
- Jevtana® (Cabazitaxel)
- Scalp Hypothermia During Chemotherapy to Prevent Hair Loss (NCD 110.6)

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This information is being distributed to you for personal reference. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific CD Provisions for coverage, limitations, and exclusions as stated in the Member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member’s EOC/SB, the member’s EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy, however, Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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I. COVERAGE

**Coverage Statement:** Chemotherapy, and associated drugs and treatments are covered when Medicare coverage criteria are met.

**Guidelines/Notes:**

1. **Chemotherapy, Immunotherapy and Hormonal Agents**
   
   Chemotherapy, immunotherapy, and hormonal agents are covered when medically indicated and used according to FDA approved indications or as a part of an anticancer chemotherapeutic regimen or cancer treatment regimen.

   FDA approved drug or biological is one that has received final marketing approval by the Food & Drug Administration (FDA) and, as a part of its labeling, contains its recommended uses and dosages as well as adverse reactions and recommended precautions in using it.

   See the *Medicare Benefit Policy Manual, Chapter 15, §50.4.1 - Approved Use of Drug.* (Accessed October 9, 2018)

2. **Off-label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen**
   
   Effective January 1, 1994, off-label, medically accepted indications of Food and Drug Administration-(FDA) approved drugs and biologicals used in an anti-cancer chemotherapeutic regimen are identified under the conditions described below.

   A regimen is a combination of anti-cancer agents clinically recognized for the treatment of a specific type of cancer.

   Off-label, medically accepted indications are supported in either one or more of the compendia or in peer-reviewed medical literature. Compendia documentation or peer-reviewed literature supporting off-label use by the treating physician may also be requested.

   **Compendia List**
   
   Do not deny coverage based solely on the absence of FDA-approved labeling for the use, if the use is supported by any of the following compendia and the use is not listed as unsupported, not indicated, not recommended, or equivalent terms, in any of the following compendia:

   - American Hospital Formulary Service-Drug Information (AHFS-DI) (Existing)
   - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium (Effective June 5, 2008). For NCCN access, see below.
   - Micromedex DrugDex (Effective June 10, 2008)
Clinical Pharmacology (Effective July 2, 2008)
Lexi-Drugs (Effective August 12, 2015)

The listed compendia employ various rating and recommendation systems that may not be readily cross-walked from compendium to compendium.

In general, a use is identified by a compendium as medically accepted if the:

- indication is a Category 1 or 2A in NCCN, or Class I, Class IIa, or Class IIb in DrugDex; or,
- narrative text in AHFS-DI or Clinical Pharmacology is supportive, or
- indication is listed in Lexi-Drugs as “Use: Off-Label” and rated as “Evidence Level A”

A use is not medically accepted by a compendium if the:

- indication is a Category 3 in NCCN or a Class III in DrugDex; or,
- narrative text in AHFS or Clinical Pharmacology is “not supportive,” or
- indication is listed in Lexi-Drugs as “Use: Unsupported”

The complete absence of narrative text on a use is considered neither supportive nor non-supportive.

Compendia Access for providers (NCCN):

The NCCN Drugs and Biologics Compendium (NCCN Compendium®) is available at https://www.nccn.org/professionals/drug_compendium/content/contents.asp. (Accessed October 9, 2018)

For convenience, participating providers can access the link to the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium on the provider portal at https://www.unitedhealthcareonline.com [Menu > Resource Library > NCCN Drugs and Biologics Compendium]. (Accessed October 9, 2018)

Important Notes:
- The Oncology program described at this link applies ONLY to commercial members covered by UnitedHealthcare or Oxford Health Plan at this time. Guideline 2 above describes Medicare requirements regarding the use of compendia and peer-reviewed medical literature.
- For other compendia referenced in Guideline 2, free access is not available at this time through UnitedHealthcareOnline.

Use Supported by Clinical Research That Appears in Peer-Reviewed Medical Literature

Peer-reviewed medical literature may appear in scientific, medical, and pharmaceutical publications in which original manuscripts are published, only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication. In-house publications of entities whose business relates to the manufacture, sale, or distribution of pharmaceutical products are excluded from consideration. Abstracts (including meeting abstracts) are excluded from consideration.

In determining whether an off-label use is supported, evaluate the evidence in published, peer-reviewed medical literature listed below. When evaluating this literature, consider (among other things) the following:

- Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence
- Whether the administered chemotherapy regimen is adequately represented in the published evidence
- Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients
- Whether the study is appropriate to address the clinical question, consider:
  - Whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover.);
  - That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs; and,
  - That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.

Use peer-reviewed medical literature appearing in the regular editions of the following publications, not to include supplement editions privately funded by parties with a vested interest in the recommendations of the authors:
- American Journal of Medicine;
- Annals of Internal Medicine;
- Annals of Oncology;
- Annals of Surgical Oncology;
- Biology of Blood and Marrow Transplantation;
- Blood;
- Bone Marrow Transplantation;
- British Journal of Cancer;
- British Journal of Hematology;
- British Medical Journal;
- Cancer;
- Clinical Cancer Research;
- Drugs;
- European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology);
- Gynecologic Oncology;
- International Journal of Radiation, Oncology, Biology, and Physics;
- The Journal of the American Medical Association;
- Journal of Clinical Oncology;
- Journal of the National Cancer Institute;
- Journal of the National Comprehensive Cancer Network (NCCN);
- Journal of Urology;
- Lancet;
- Lancet Oncology;
- Leukemia;
- The New England Journal of Medicine; or
- Radiation Oncology

Notes:
- *FDA-approved drugs and biologicals may also be considered for use in the determination of medically accepted indications for off-label use if to be reasonable and necessary.*
- *If a use is identified as not indicated by the Centers for Medicare and Medicaid Services (CMS) or the FDA, or if a use is specifically identified as not indicated in one or more of
the compendia listed, or it’s determined, based on peer-reviewed medical literature, that a particular use of a drug is not safe and effective, the off-label usage is not supported and, therefore, the drug is not covered. (This criteria does not apply for the determination of Drug eligibility for Part D.)

See the Medicare Benefit Policy Manual, Chapter 15, §50.4.5 - Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen. (Accessed October 9, 2018)

3. National Cancer Institute (NCI) Designated "Group C" Drugs

Under its Cancer Therapy Evaluation, the Division of Cancer Treatment of the National Cancer Institute (NCI), in cooperation with the Food and Drug Administration, approves and distributes certain drugs for use in treating terminally ill cancer patients. One group of these drugs, designated as Group C drugs, unlike other drugs distributed by the NCI, are not limited to use in clinical trials for the purpose of testing their efficacy. Drugs are classified as Group C drugs only if there is sufficient evidence demonstrating their efficacy within a tumor type and that they can be safely administered.

National Cancer Institute (NCI) designated "Group C" drugs and the related hospital stay is covered if all other applicable coverage requirements are satisfied.

Refer to the NCD for Certain Drugs Distributed by the National Cancer Institute (110.2) for coverage requirements. (Accessed October 9, 2018)

4. Examples of not Reasonable and Necessary

Determinations as to whether medication is reasonable and necessary for an individual patient should be made on the same basis as all other such determinations (i.e., with the advice of medical consultants and with reference to accepted standards of medical practice and the medical circumstances of the individual case). The following guidelines identify three categories with specific examples of situations in which medications would not be reasonable and necessary according to accepted standards of medical practice:

a. Not for Particular Illness: Medications given for a purpose other than the treatment of a particular condition, illness, or injury are not covered (except for certain immunizations). Charges for medications, e.g., vitamins, given simply for the general good and welfare of the patient and not as accepted therapies for a particular illness are excluded from coverage.

b. Injection Method Not Indicated: Medication given by injection (parenterally) is not covered if standard medical practice indicates that the administration of the medication by mouth (orally) is effective and is an accepted or preferred method of administration. For example, the accepted standard of medical practice for the treatment of certain diseases is to initiate therapy with parenteral penicillin and to complete therapy with oral penicillin. UnitedHealthcare Medicare excludes the entire charge for penicillin injections given after the initiation of therapy if oral penicillin is indicated unless there are special medical circumstances that justify additional injections.

c. Excessive Medications: Medications administered for treatment of a disease and which exceed the frequency or duration of injections indicated by accepted standards of medical practice are not covered. For example, the accepted standard of medical practice in the maintenance treatment of pernicious anemia is one vitamin B-12 injection per month. UnitedHealthcare excludes the entire charge for injections given in excess of this frequency unless there are special medical circumstances that justify additional
injections.

Notes:
- UnitedHealthcare will supplement the guidelines as necessary with guidelines concerning appropriate use of specific injections in other situations. They will use the guidelines to screen out questionable cases for special review, further development, or denial when the injection billed for would not be reasonable and necessary. They will coordinate any type of drug treatment review with the Quality Improvement Organization (QIO).
- If a medication is determined not to be reasonable and necessary for diagnosis or treatment of an illness or injury according to these guidelines, UnitedHealthcare excludes the entire charge (i.e., for both the drug and its administration). Also, UnitedHealthcare excludes from payment any charges for other services (such as office visits) which were primarily for the purpose of administering a non-covered injection (i.e., an injection that is not reasonable and necessary for the diagnosis or treatment of an illness or injury).

Refer to the Medical Benefit Policy Manual, Chapter 15, §50.4.3 - Examples of Not Reasonable and Necessary. (Accessed October 9, 2018)

5. Medicare Approved Clinical Trials: [Oxaliplatin (Elonxatin®), Irinotecan (Camptosar®), Cetuximab (Erbitux®), and Bevacizumab (Avastin®)]
Members may be eligible to participate in a Medicare approved clinical trial, including anticancer chemotherapy for colorectal cancer, when criteria are met.

Effective January 28, 2005, the off-label use of clinical items and services, including the use of the studied drugs oxaliplatin, irinotecan, cetuximab, or bevacizumab, are covered in specific clinical trials identified by the Centers for Medicare & Medicaid Services (CMS). The clinical trials identified by CMS for coverage of clinical items and services are sponsored by the National Cancer Institute (NCI) and study the use of one or more off-label uses of these four drugs in colorectal cancer and in other cancer types.

Refer to the NCD for Anti-Cancer Chemotherapy for Colorectal Cancer (110.17). (Accessed October 9, 2018)

The list of Medicare approved clinical trials is available at https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html. (Accessed October 9, 2018)

For payment rules for NCDs requiring CED, see the Coverage Summary for Experimental Procedures and Items, Investigational Devices and Clinical Trials.

6. Examples of chemotherapy services include, but are not limited to:
a. Oral Anti-cancer Drugs
Oral anticancer drugs prescribed as anticancer chemotherapeutic agents are covered when all of the following criteria are met:
- Approved by the Food and Drug Administration (FDA)
- Prescribed by a physician or other practitioner licensed under state law to prescribe such drugs as anticancer chemotherapeutic agents
- Contains or is metabolized (prodrug) into the same active ingredients as a non-self-administrated anticancer chemotherapeutic drug or biological that is covered when furnished incident to a physician's service
- Has the same chemical/generic name as non-self-administrable drug indicated by the
FDA’s Approved Drug Products, Physician's Desk Reference (PDR), or an authoritative drug compendium

- Used for the same indications, including off-labeled uses, as the non-self-administered version of the drug
- Considered reasonable and necessary for the individual member

**Note:** Members may have additional coverage for oral anti-cancer under the Part D Prescription Drug Plan, which are not covered in this Coverage Summary. Refer to the Member’s Pharmacy Booklet or contact the Prescription Solutions Customer Service Department to determine coverage eligibility for prescription drug plan benefit. For detailed coverage requirements, see the Medicare Benefit Policy Manual, Chapter 15, §50.5.3 Oral Anti-Cancer Drugs. (Accessed October 9, 2018)

For claims payment and coding information, see the Medicare Claims Processing Manual, Chapter 17, §80.1 Oral Cancer Drugs. (Accessed October 9, 2018)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp. (Accessed February 21, 2019)

### b. Anti-nausea (anti-emetic) drugs

Oral anti-nausea (anti-emetic) drugs **are covered** when all of the following criteria are met:

- Approved by the FDA for use as anti-emetics
- Administered by the treating physician or in accordance with a written order from the physician as part of a cancer chemotherapy regimen
- Administered with a particular chemotherapy treatment and initiated within 2 hours of the administration of the chemotherapeutic agent and may be continued for a period not to exceed 48 hours from that time
- Used as a full therapeutic replacement for the intravenous anti-emetic drugs that would have otherwise been administered at the time of the chemotherapy treatment

**Note:** Intravenous anti-emetics may be covered (subject to the rules of medical necessity) when furnished to the patients who fail on oral anti-emetics therapy.

**Note:** Members may have additional coverage for oral anti-emetic under the Part D Prescription Drug Plan, which are not covered in this Coverage Summary. Refer to the Member’s Pharmacy Booklet or contact the Prescription Solutions Customer Service Department to determine coverage eligibility for prescription drug plan benefit. For detailed coverage requirement, see the Medicare Benefit Policy Manual, Chapter 15, §50.5.4 - Oral Anti-Nausea (Anti-Emetic) Drugs. (Accessed October 9, 2018)

For claims payment and coding information, refer to the Medicare Claims Processing Manual, Chapter 17, §80.2 - Oral Anti-emetic Drugs Used as Full Replacement for Intravenous Anti-Emetic Drugs as Part of a Cancer Chemotherapeutic Regiment. (Accessed October 9, 2018)

**Injection form of Anzemet (dolasetron mesylate) – New prescribing information:** The FDA added a new contraindication to the prescribing information; advising that the injection form of Anzemet (dolasetron mesylate) should no longer be used to prevent nausea and vomiting associated with cancer chemotherapy (CINV) in pediatric and adult patients. For additional information, refer to the FDA website at
c. Aprepitant

Aprepitant for chemotherapy-induced emesis is covered when Medicare criteria are met. For the list of approved agents and specific coverage information. See the NCD for Aprepitant for Chemotherapy-Induced Emesis (110.18). (Accessed October 9, 2018)

d. Abarelix

Abarelix is **reasonable and necessary and covered** as a palliative treatment in patients with advanced symptomatic prostate cancer: (1) in whom GnRH agonist therapy is not appropriate; (2) who decline surgical castration; and (3) who present with one of the following:

1) Risk of neurological compromise due to metastases,
2) Ureteral or bladder outlet obstruction due to local encroachment or metastatic disease, or,
3) Severe bone pain from skeletal metastases persisting on narcotic analgesia.

CMS determined that the evidence is not adequate to conclude that abarelix is reasonable and necessary for indications other than that specified above. All other uses of abarelix are not covered. In light of the concern regarding safety risks of abarelix, off-label uses that may appear in listed statutory drug compendia on which Medicare and its contractors rely to make coverage determinations will remain non-covered unless CMS extends coverage through a reconsideration of the NCD.

Refer to the NCD for Abarelix for the Treatment of Prostate Cancer (110.19) for additional coverage requirement and information. (Accessed October 9, 2018)

**Note:** Withdrawal of Abarelix from the U.S. Market: In May 2005, because of limited sales, Abarelix was withdrawn from the U.S. market and is available only to patients who are currently receiving the medicine. For more information, refer to https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3159401/ and https://www.allinahealth.org/CCS/doc/Thomson%20Detailed%20Drugs/47/600007.htm. (Accessed April 8, 2019)

e. Inpatient or outpatient oncology services (includes infusion clinic services) are covered. Refer to the UnitedHealthcare Commercial Utilization Review Guideline (URG) for Chemotherapy Observation and Inpatient Hospitalization. See the Instruction for Use within this URG document. URGs apply clinical guidelines to determine whether the health care services provided or planned for an individual member/enrollee are the most appropriate and cost-effective services under the specific circumstances. (Accessed October 9, 2018)

f. Osmotic Blood Brain Barrier Disruption (BBBD)

Osmotic blood brain barrier disruption (BBBD) the treatment of brain tumors is **not covered**.

**BBBD** is the disruption of the tight junctions between the endothelial cells that line the capillaries in the brain accomplished by osmotic disruption, bradykinin or irradiation. Theoretically, disruption of the BBB may, in the treatment of brain tumors, increase the concentration of chemotherapy drugs delivered to the tumor and may prolong the drug-tumor contact time.
Osmotic disruption of the BBB is the most common technique used. Chemotherapeutic agents are given in conjunction with barrier disruption. The BBBD process includes all items and services necessary to perform the procedure, including hospitalization, monitoring, and repeated imaging procedures. See the NCD for Blood Brain Barrier Osmotic Disruption for Treatment of Brain Tumors (110.20). (Accessed October 9, 2018)

g. **Scalp Hypothermia during Chemotherapy**
Scalp hypothermia during chemotherapy for prevention of hair loss (ice bag and cool bandages) may be used as supplies during chemotherapy but are not recognized for reimbursement. See the NCD for Scalp Hypothermia During Chemotherapy (110.6). (Accessed October 9, 2018)

h. **Local Hyperthermia**
Local hyperthermia is not covered when used alone or in connection with chemotherapy. It is covered when used in connection with radiation therapy for the treatment of primary or metastatic cutaneous or subcutaneous superficial malignancies. See the NCD for Hyperthermia for Treatment of Cancer (110.1). (Accessed October 9, 2018)

Also see the Coverage Summary for Radiologic Therapeutic Procedures.

i. **Sipuleucel-T (PROVENGE®)**

**On-label Indication:**
- Effective for services performed on or after June 30, 2011, the Centers for Medicare and Medicaid Services (CMS) proposed that the evidence is adequate to conclude that the use of autologous cellular immunotherapy treatment - sipuleucel-T; PROVENGE® improves health outcomes for Medicare beneficiaries with for asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer, and thus is reasonable and necessary for this on-label indication under 1862(a)(1)(A) of the Social Security Act. Medicare will allow a maximum of three (3) infusions per lifetime. See the NCD for Autologous Cellular Immunotherapy Treatment (110.22). (Accessed October 9, 2018)

- There are no LCDs for Sipuleucel-T (PROVENGE®), but LCAs exist. Compliance with these articles is required where applicable. The LCAs for Sipuleucel-T (PROVENGE®) are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp. (Accessed February 21, 2019)


**Off-label Indications:**
- Effective for services performed on or after June 30, 2011, coverage of all off-label uses of autologous cellular immunotherapy treatment – sipuleucel-T; PROVENGE® for the treatment of prostate cancer is left to the discretion of the local Medicare Administrative Contractors. See the NCD for Autologous Cellular Immunotherapy Treatment (110.22). (Accessed October 9, 2018)

- There are no LCDs for Sipuleucel-T (PROVENGE®), but LCAs exist. Compliance

- **For states with no LCDs/LCAs**, refer to **Guideline 1** and **Guideline 2** of this coverage summary for Medicare guidelines for covered chemotherapy services and the use of compendia and evidence-based medical literature in determining coverage for this medication.

### j. Rituximab (Rituxan®)

Rituximab (Rituxan®) can be used for chemotherapeutic indications as well as for non-chemotherapeutic indications. **For non-chemotherapeutic indications, refer to the Coverage Summary for Medications/Drugs (Outpatient/Part B).**

- Medicare does not have a National Coverage Determination (NCD) for Rituximab (Rituxan®)
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCD/LCA, refer to the LCD Availability Grid (Attachment A).
- **For states with no LCDs/LCAs**, refer to the National Government Services LCD for Drugs and Biologicals, Coverage of, for Label and Off-Label Uses (L33394).
  
  **(IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)**
  
  - **Committee approval date:** October 16, 2018
  - **Accessed June 4, 2019**

### k. Erythropoietin; refer to the Coverage Summary for Medications/Drugs (Outpatient/Part B) for coverage guideline.

### l. Other Specific Chemotherapeutic Agents

For coverage guideline for specific chemotherapeutic agents:


2) If there are no applicable LCDs or LCAs found, refer to **Guideline 1** and **Guideline 2** of this Coverage summary for Medicare guidelines for covered chemotherapy services and the use of compendia and evidence-based medical literature in determining coverage for specific medication.

### 7. Shortage of Leucovorin (J0640)

There is currently a nationwide shortage of injectable racemic leucovorin, available only as a generic drug and only from two manufacturers in the US (Bedford Laboratories and Teva Pharmaceuticals). According to the FDA, the shortages are due to manufacturing delays; however, the American Society of Health-System Pharmacists (ASHP) reports that Bedford cannot provide a reason for the shortage. Information on current availability of specific vial sizes and expected release dates for others can be found on the FDA website at http://www.accessdata.fda.gov/scripts/drugshortages/default.cfm and American Society of Health-System Pharmacists (ASHP Current Drug Shortage Bulletin). (Accessed October 9, 2018)

For patients affected by this shortage, the UnitedHealthcare Medicare plan will consider
levoleukovorin (J0641) as an alternative for leucovorin (J0640).

II. DEFINITIONS

III. REFERENCES

The NCCN Drugs and Biologics Compendium (NCCN Compendium®).
http://www.nccn.org/professionals/drug_compendium/content/contents.asp (Accessed October 9, 2018)

IV. REVISION HISTORY

04/01/2019  • Updated policy introduction; added language to clarify:
  o There are instances where [the Coverage Summary] may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG)
  o In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5)

09/18/2018  • Retitled reference link that directs users to UnitedHealthcare Commercial policy

10/16/2018  Annual review with no updates.

09/18/2018  Updated Local Coverage Determination (LCD) Availability Grid; removed instruction to “use the applicable LCD based on member’s residence/place and type of service” (this note only applies when selecting the appropriate DME LCD Policy)

01/16/2018  Re-review with the following update:

          Guideline 6.j Rituximab (Rituxan®) - Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

10/17/2017  Annual review with no updates.

10/18/2016  Annual review with the following update:

          Guideline 2 (Off-label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen) updated to include the following:
            - Updated Compendia list which includes Lexi-Drugs
            - Other related language pertaining to Lexi-Drugs

04/19/2016  Re-review with the following updates:
          • Guideline #6.d (Abarelix) – Deleted reference to the “LCDs for Abarelix for the Treatment of Prostate Cancer”; these LCDs are no longer available.
          • Updated reference link(s) of the applicable LCDs to reflect the condensed link.

11/17/2015  Annual review with no updates.

10/01/2015  Updated reference link(s) to the applicable Medicare Administrative Contractor
(MAC) LCDs to reflect the new updated LCD/ID number effective October 1, 2015.

04/21/2015  Guideline #5 (Medicare Approved Clinical Trials)
- Added reference link to the list of Medicare approved clinical trials.
- Updated the payment information pertaining to NCDs requiring CED.

12/16/2014  Annual review with the following updates:
Reorganized policy content.

Guideline 1 (Chemotherapy, Immunotherapy and Hormonal Agents)
- Moved definition of FDA approved drug or biological from Definition section
- Added reference link to the Medicare Benefit Policy Manual, Chapter 15, §50.4.1 - Approved Use of Drug
- Removed the notes pertaining to claims payment and coding information

Guideline 3 (National Cancer Institute (NCI) Designated "Group C" Drugs) - Updated to include additional coverage information based on the reference NCD for Certain Drugs Distributed by the National Cancer Institute (110.2)

Guideline 5 (Medicare Approved Clinical Trials)
- Added Oxaliplatin (Elloxatin™), Irinotecan (Camptosar®), Cetuximab (Erbitux™), and Bevacizumab (Avastin™) to the title
- Updated to include additional coverage information based on the referenced NCD for Anti-Cancer Chemotherapy for Colorectal Cancer (110.17)
- Added payment information and reference link to the Coverage Summary for Experimental Procedures and Items, Investigational Devices and Clinical Trials

Guideline 6.e.1 (Aprepitant) - Removed the detailed coverage information which was based on the NCD for Aprepitant for Chemotherapy Induced Emesis (110.18); added a reference link to this NCD

Guideline 6.e.1 (Inpatient or outpatient oncology services)
- Re-numbered to 6.e
- Added the description of Utilization Review Guideline (URG)

Guideline 6.e.2 (Follow up appointments to monitor response to treatments)
- Removed; no CMS reference available

Guideline 6.e.3 (Other related services administered on a day other than the treatment day)
- Removed; no CMS reference available

Guideline 6.e.4 (Outpatient chemotherapy labs taken on same day as chemotherapy treatment)
- Removed; no CMS reference available

Guideline 6.f (Osmotic Blood Brain Barrier Disruption)
- Moved the definition of BBBD from Definition section

Guideline 6.j [Rituximab (Rituxan®)]
- Removed the detailed coverage guideline which was based on the National Government Services Article for Rituximab (Rituxan®) (effective 2010) - Related to LCD L25820 (A49636); added reference link to this LCD
Guideline 6.k (Erythropoietin)
- Added with reference link to the Coverage Summary for Medications/Drugs (Outpatient/Part B)

Guideline 6.l (Other Specific Chemotherapeutic Agents)
- Removed guidelines for the following specific chemotherapeutic agents:
  - Bevacizumab (Avastin®)
  - Denosumab (Xgeva®, Prolia®)
  - Panitumumab (Vectibix®)
  - Azacitidine (Vidaza)
  - Bortezomab (Velcade®)
  - Cabazitaxel (Jevtana®)
  - Cetuximab (Erbitux®)
  - Doxorubicin HCL liquid (Doxil®, Caelyz®)
  - Gemcitabine (Gemzar®)
  - Ipilimumab (Yervoy®)
  - Paclitaxil Protein bound (Abraxane®)
  - Premetrexed (Alimta®)
  - Topotecan (Hycamtin®)
  - Trastuzumab (Herceptin®)
- Added language to indicate:
  For coverage guidelines for specific chemotherapeutic agents,
  3) Check for available LCDs or Local Articles at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?
  4) If there are no applicable LCDs or Local Articles found, refer to Guideline #1 and Guideline #2 of this Coverage summary for Medicare guidelines for covered chemotherapy services and the use of compendia and evidence-based medical literature in determining coverage for specific medication.

Definitions
- Removed the following definitions of (already defined in Guideline section):
  - Anticancer Chemotherapeutic Regimen
  - Cancer Treatment Regimen
  - "Group C" Drugs (as defined by the NCI)
  - Unlabeled (off label) Use of a Drug
- Moved the following definitions to Guideline section:
  - Blood Brain Barrier Disruption (BBBD)
  - Utilization Review Guidelines (URG)
  - FDA Approved Drug

10/21/2014 Guidelines #1.b [Oral Anti-nausea (anti-emetic) drugs] - Revised heading of guideline to “Anti-nausea (anti-emetic) drugs” and added new FDA contraindication to the prescribing information of Anzement (dolasetron mesylate).

08/20/2013 Guidelines #1.c. (Aprepitant) - Revised guideline in accordance with the Medicare Decision Memorandum for Aprepitant for Chemotherapy Induced Emesis

12/17/2012 Annual review; Guidelines 9.c Panitumumab (Vectibix®) updated to state that there are no LCDs available at this time as the only available Local Article, i.e., A46094
was retired effective 06/1/2012.

06/18/2012 Guidelines # 1.e Chemotherapy, Immunotherapy and Hormonal Agents updated to include a reference/link to the UHC Utilization Review Guidelines for Chemotherapy Observation and Inpatient Hospitalization. (Internal Use Only)

11/18/2011 Annual review with the following updates:
- The Coverage Summary title was changed to “Chemotherapy, and Associated Drugs and Treatment”. CS Index was also added
- Guidelines #3 updated to include the Compendia access for providers
- Guidelines #4 Specific Chemotherapeutic Agents was updated to include guidelines for the following: a) Bevacizumab (Avastin®), b) Denosumab (Xgeva®, Prolia®), c) Panitumumab (Vectibix®), e) Sipuleucel-T (PROVENGE®) and f) Other Agents which includes Azacitidine (Vidaza), Bortezomib (Velcade®), Cetuximab (Erbitux®), Doxorubicin HCL liquid (Doxil®, Caelyx®), Gemcitabine (Gemzar®), Ipilimumab (Yervoy®), Paclitaxil Protein bound (Abraxane®),
- Premetrexed (Alimta®), Topetecan (Hycamtin®) and Trastuzumab (Herceptin®)

06/30/2011 Added Guidelines #1 Rituximab (Rituxan®)

05/02/2011 Updated Guidelines #1.e (Oral Anti-cancer Drugs)-LCD for Chemotherapy Agents, Anti-Cancer no longer exists

04/14/2011 Updated Guidelines #1.h (Abarelix) to include a note pertaining to the withdrawal of Abarelix from the U.S. market

11/16/2010 Updated Guidelines #3-Off-label Use of Drugs and Biological in an Anti-Cancer Chemotherapeutic Regimen

Guidelines # 5 - Examples of Not Reasonable and Necessary to include the most current benefit language based on the Medicare Benefit Policy Manual, Chapter 15, §50.4

08/24/2010 Updated to include a note requiring a primary diagnosis code for the payment of injectable medications; added a note regarding the shortage of shortage of Leucovorin (J0640).

V. ATTACHMENT(S)

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
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<td>L33746</td>
<td>Rituximab (Rituxan®)</td>
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<td>First Coast Service Options, Inc.</td>
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<td>Drugs and Biologicals, Coverage of, for Label and Off-Label Uses</td>
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End of Attachment A