Regence Oregon and Utah | Regence Idaho and select counties of Washington

Medical Policy Manual Transplant, Policy No. 45

Hematopoietic Cell Transplantation Index

Effective: November 1, 2018

Next Review: September 2019
Last Review: September 2018

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

HEMATOPOIETIC CELL TRANSPLANT (HCT) INDICATIONS

There are a number of indications for which hematopoietic cell transplantation (HCT) may be considered as a treatment option. The list below provides links to policies and medical necessity criteria for specific HCT indications.

Hodgkin Lymphoma (HL)
Light-Chain (AL) Amyloidosis
Multiple Myeloma (MM)
Myelodysplastic Syndromes (MDS)
Myeloproliferative Neoplasms (MPN)
Non-Hodgkin Lymphomas (NHL)
POEMS Syndrome
Small Lymphocytic Lymphoma
Solid Tumors – Adults
Solid Tumors – Childhood
Waldenström's macroglobulinemia

Date of Origin: *May 2010*