Policy Number	**SUR703.044**
Policy Effective Date	**06/15/2026**

Hematopoietic Cell Transplantation for Solid Tumors of Childhood

Table of Contents
Coverage
Policy Guidelines
Description
Rationale
Coding
References
Policy History

Related Policies (if applicable)
SUR703.042: Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas
SUR703.045: Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors
SUR703.039: Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma
SUR703.002: Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Coverage

Autologous
Autologous hematopoietic cell transplantation (HCT) **may be considered medically necessary** for:

- Initial treatment of high-risk neuroblastoma (see NOTE 1),
- Recurrent or refractory neuroblastoma,
- Initial treatment of high-risk Ewing sarcoma,
- Recurrent or refractory Ewing sarcoma,
- Metastatic retinoblastoma; and
- High-risk relapsed Wilms tumor.

Autologous HCT **is considered experimental, investigational and/or unproven** as initial treatment of low- or intermediate-risk neuroblastoma, initial treatment of low- or intermediate-risk Ewing sarcoma, and for other solid tumors of childhood including, but not limited to, the following:

- Rhabdomyosarcoma,
- Osteosarcoma, and
- Retinoblastoma without metastasis.

Tandem Autologous

Tandem autologous HCT **may be considered medically necessary** for high-risk neuroblastoma (see NOTE 1).

NOTE 1: In general, age, *MYCN* oncogene amplification, and/or 11q aberrations may correlate to high-risk neuroblastoma statuses for select tumor stages. Refer to the International Neuroblastoma Risk Group Classification System in the Description section for these associations and further details.

Tandem autologous HCT **is considered experimental, investigational and/or unproven** for the treatment of all other types of pediatric solid tumors except high-risk neuroblastoma, as noted above.

Allogeneic

Allogeneic (myeloablative or nonmyeloablative) HCT **is considered experimental, investigational and/or unproven** for treatment of pediatric solid tumors.

Salvage allogeneic HCT for pediatric solid tumors that relapse after autologous transplant or fail to respond **is considered experimental, investigational and/or unproven**.

Policy Guidelines

This policy addresses peripheral neuroblastoma arising from the peripheral nervous system (i.e., neuroblastoma, ganglioneuroblastoma, ganglioneuroma).

Hematopoietic cell transplantation refers to any source of stem cells, i.e., autologous, allogeneic, syngeneic, or umbilical cord blood.

Relapse is defined as tumor recurrence after a prior complete response.

Primary refractory disease is defined as a tumor that does not achieve a complete remission after initial standard-dose chemotherapy.

Description

Hematopoietic cell transplantation (HCT) is a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone-marrow-toxic doses of drugs, with or without whole body radiotherapy. Stem cells may be obtained from the transplant recipient (autologous HCT) or harvested from a donor (allogeneic HCT). Stem cells may be harvested from bone marrow, peripheral blood, or umbilical cord blood shortly after delivery of neonates.

Solid Tumors of Childhood

Solid tumors of childhood arise from mesodermal, ectodermal, and endodermal cells of origin. (1) Some common solid tumors of childhood are neuroblastoma, Ewing sarcoma/Ewing sarcoma family of tumors (ESFT), Wilms tumor, rhabdomyosarcoma, osteosarcoma, and retinoblastoma.

General Treatment

The prognosis for pediatric solid tumors has improved more recently, mostly due to the application of multiagent chemotherapy and improvements in local control therapy (including aggressive surgery and advancements in radiotherapy). (2) However, patients with metastatic, refractory, or recurrent disease continue to have poor prognoses, and these "high-risk" patients are candidates for more aggressive therapy, including autologous HCT, to improve event-free survival (EFS) and overall survival (OS).

Descriptions of pediatric-onset solid tumors addressed herein are as follows.

Peripheral Neuroblastoma

Neuroblastoma is the most common extracranial solid tumor of childhood, (1) with approximately 90% of cases presenting in children younger than 5 years of age. These tumors originate where sympathetic nervous system tissue is present, within the adrenal medulla or paraspinal sympathetic ganglia, but have diverse clinical behavior depending on a variety of risk factors.

Patients with neuroblastoma are stratified into prognostic risk groups (low, intermediate, high) that determine treatment plans. Risk variables include age at diagnosis, clinical stage of disease, tumor histology, and certain molecular characteristics, including the presence of the *MYCN* oncogene. Tumor histology is categorized as favorable or unfavorable according to the degree of tumor differentiation, the proportion of tumor stromal component, and index of cellular proliferation. (3) It is well-established that *MYCN* amplification is associated with rapid tumor progression and a poor prognosis, (4) even in the setting of other coexisting favorable factors. Loss of heterozygosity (LOH) at chromosome arms 1p and 11q frequently occurs in neuroblastoma. (5) Although 1p LOH is associated with *MYCN* amplification, 11q is usually found in tumors without this abnormality. (5) Some recent studies have shown that 1p LOH and unbalanced 11q LOH are strongly associated with outcome in patients with neuroblastoma, and both are independently predictive of worse progression-free survival (PFS) in patients with low- and intermediate-risk disease. (3) Although the use of these LOH markers in assigning treatment in patients is evolving, they may prove useful to stratify treatment.

In the early 1990s, a uniform clinical staging system based on surgical resectability and distant spread, the International Neuroblastoma Staging System (INSS), was adopted by pediatric cooperative groups (see Table 1).

Table 1. International Neuroblastoma Staging System

Stage	Description
1	Localized tumor with complete gross excision, with or without microscopic residual disease; lymph nodes negative for tumor
2A	Localized tumor with incomplete gross excision; lymph nodes negative for tumor
2B	Localized tumor with or without complete gross excision, with ipsilateral lymph nodes positive for tumor
3	Unresectable unilateral tumor infiltrating across the midline, with or without regional lymph node involvement; or localized unilateral tumor with contralateral regional lymph node involvement; or midline tumor with bilateral extension by infiltration or by lymph node involvement
4	Any primary tumor with dissemination to distant lymph nodes, bone, bone marrow, liver, skin, and/or other organs, except as defined for stage 4S
4S	Localized primary tumor as defined for stage 1, 2A, or 2B, with dissemination limited to skin, liver, and/or bone marrow (marrow involvement less than 10%), limited to children younger than 1 year of age

The low-risk group includes patients younger than 1 year of age with stage 1, 2, or 4S with favorable histopathologic findings and no *MYCN* oncogene amplification. High-risk neuroblastoma is characterized by age older than 1 year, disseminated disease, *MYCN* oncogene amplification, and unfavorable histopathologic findings.

The International Neuroblastoma Risk Group (2009) proposed a revised staging/classification system, which incorporated pretreatment imaging parameters instead of surgical findings (see Tables 2 and 3). (6, 7)

Table 2. International Neuroblastoma Risk Group Staging System (6)

Stage	Description
L1	Localized tumor not involving vital structures as defined by the list of Image-Defined Risk Factors and confined to one body compartment
L2	Locoregional tumor with presence of one or more Image-Defined Risk Factors
M	Distant metastatic disease (except stage MS)
MS	Metastatic disease in children younger than 18 months with metastases confined to skin, liver, and/or bone marrow

Table 3. International Neuroblastoma Risk Group Classification System (7)

INRG Stage	Age (mos)	Histological Category	Grade of Tumor Differentiation	*MYCN*	11q Aberration	Ploidy	Pretreatment Risk Group

L1/L2		GN maturing; GNB intermixed					Very low
L1		Any, except GN maturing or GNB intermixed		NA			Very low
				Amp			High
L2	<18	Any, except GN maturing or GNB intermixed		NA	No		Low
					Yes		Intermediate
	≥18	GNB nodular; neuroblastoma	Differentiating	NA	No		Low
					Yes		Intermediate
			Poorly differentiated or undifferentiated	NA			
				Amp			High
M	<18			NA		Hyper-diploid	Low
	<12			NA		Diploid	Intermediate
	12 to <18			NA		Diploid	Intermediate
	<18			Amp			High
	≥18						High
MS	<18			NA	No		Very low
					Yes		High
				Amp			High

Amp: amplified; GN: ganglioneuroma; GNB: ganglioneuroblastoma; INRG: International Neuroblastoma Risk Group; mos: months; NA: not amplified.

Treatment

In general, most patients with low-stage disease have excellent outcomes with minimal therapy; and with INSS stage-1 disease, most patients can be treated by surgery alone. Most infants, even with disseminated disease, have favorable outcomes with chemotherapy and surgery. (8)

For intermediate-risk disease, moderately intensive multiagent chemotherapy is the mainstay of therapy. (9) Surgery is needed to obtain a diagnosis, and the extent of resection necessary to obtain an optimal outcome is not clearly established. (10) Patients at high-risk have historically had very low (<15%) long-term overall survival. Current therapy for high-risk disease typically includes an aggressive multimodal approach with chemotherapy, surgical resection, and radiotherapy. (11)

Treatment of recurrent disease is determined by the risk group at diagnosis and the extent of disease and age of the patient at recurrence.

<u>Ewing Sarcoma Family of Tumors</u>

Ewing sarcoma family of tumors (ESFT) encompasses a group of tumors that share some degree of neuroglial differentiation and a characteristic underlying molecular pathogenesis

(chromosomal translocation). (12) The translocation usually involves chromosome 22 and results in fusion of the *EWS* gene with one of the members of the ETS (E26 transformation-specific) family of transcription factors, either FLI1 (90%-95%) or ERG (5%-10%). (13) These fusion products function as oncogenic aberrant transcription factors. Detection of these fusions is considered to be specific for the ESFT and helps further validate diagnosis. Included in ESFT are "classic" Ewing sarcoma of bone, extraosseous Ewing, peripheral primitive neuroectodermal tumor, and Askin tumors (chest wall).

Most commonly diagnosed in adolescence, ESFT can be found in bone (most commonly) or soft tissue; however, the spectrum of ESFT has also been described in various organ systems. Ewing is the second most common primary malignant bone tumor. (14) The most common primary sites are the pelvic bones, the long bones of the lower extremities, and the bones of the chest wall.

Treatment

Current therapy for Ewing sarcoma typically includes induction chemotherapy, followed by local control with surgery and/or radiotherapy (dependent on tumor size and location), followed by adjuvant chemotherapy. Multiagent chemotherapy, surgery, and radiotherapy have improved PFS rates in patients with localized disease to 60% to 70%. (15) The presence of metastatic disease is the most unfavorable prognostic feature, and the outcome for patients presenting with metastatic disease is poor, with 20% to 30% PFS. Other adverse prognostic factors that may categorize a patient as having "high-risk" Ewing are tumor location (e.g., patients with pelvic primaries have worse outcomes), larger tumor size, and older age of the patient. However, "high-risk" Ewing has not always been consistently defined in the literature.

<u>Rhabdomyosarcoma</u>

Rhabdomyosarcoma, the most common soft tissue sarcoma of childhood, shows skeletal muscle differentiation. The most common primary sites are the head and neck (e.g., parameningeal), genitourinary tract, and extremities. (16)

Treatment

Specific treatment is based on tumor location, resection, and node status, and may involve surgery, radiotherapy, and chemotherapy. (17) Five-year survival rates for rhabdomyosarcoma increased between 1975 and 2017 from 53% to 71% in children younger than 15 years and from 30% to 52% in patients 15 to 19 years of age. (16)

Approximately 15% of children present with metastatic disease, and despite the introduction of new drugs and intensified treatment, the 5-year survival is 20% to 30% for this "high-risk" group. (18, 19) Similarly, post relapse mortality is very high. The prognosis of metastatic disease is affected by tumor histology, age at diagnosis, the site of metastatic disease, and the number of metastatic sites. (16)

<u>Wilms Tumor</u>

Wilms tumor is the most common primary malignant renal tumor of childhood. (20) In the United States, Wilms tumor is staged using the National Wilms Tumor Study system, which is based on surgical evaluation before chemotherapy (see Table 4). (21)

Table 4. National Wilms Tumor Study Staging

Stage	Description
I	a) Tumor is limited to the kidney and completely excised; b) The tumor was not ruptured before or during removal; c) The vessels of the renal sinus are not involved beyond 2 mm; d) There is no residual tumor apparent beyond the margins of excision.
II	a) Tumor extends beyond the kidney but is completely excised; b) No residual tumor is apparent at or beyond the margins of excision; c) Tumor thrombus in vessels outside the kidney is stage II if the thrombus is removed en bloc with the tumor.
III	Residual tumor confined to the abdomen: a) Lymph nodes in the renal hilum, the periaortic chains, or beyond are found to contain tumor; b) Diffuse peritoneal contamination by the tumor; c) Implants are found on the peritoneal surfaces; d) Tumor extends beyond the surgical margins either microscopically or grossly; e) Tumor is not completely resectable because of local infiltration into vital structures.
IV	Presence of hematogenous metastases or metastases to distant lymph nodes.
V	Bilateral renal involvement at the time of initial diagnosis.

Adapted from Metzger and Dome (2005). (21)

Treatment

In the United States, National Wilms Tumor Study and Children's Oncology Group protocols are based on primary resection for unilateral tumors, followed by escalating levels of chemotherapy and radiotherapy depending on tumor stage and other prognostic factors. Tumor histology, tumor stage, molecular and genetic markers (e.g., LOH at chromosome 16q), and age (>2 years) are all associated with increased risks of recurrence and death. Wilms tumors are highly sensitive to chemotherapy and radiotherapy, and current cure rates exceed 85%. Between 10% and 15% of patients with favorable histology and 50% of patients with anaplastic tumors experience tumor progression or relapse. (22)

Similar risk-adapted strategies are being tested for the 15% of patients who experience a relapse. Success rates after relapse range from 25% to 45%. For patients with adverse prognostic factors (histologically anaplastic tumors, relapse <6 to 12 months after nephrectomy, second or subsequent relapse, relapse within the radiation field, bone or brain metastases), the EFS rate is less than 15%. (23)

Osteosarcoma

Osteosarcoma is a primary malignant bone tumor and the most common bone cancer in children and adolescents; it is characterized by infiltration of bone or osteoid by the tumor cells. (24) Peak incidence occurs around puberty, most commonly in long bones such as the femur or humerus. Osteosarcomas are characterized by variants in the *TP53* tumor suppressor gene. (25)

The prognosis of osteosarcoma has greatly improved, with 5-year survival rates increasing between 1975 and 2020 from 40% to 72% in children younger than 15 years and from 56% to 71% in 15- to 19-year-olds. (25) Prognostic factors for patients with localized disease include site and size of the primary tumor, the presence of metastases at the time of diagnosis, resection adequacy, and tumor response to neoadjuvant chemotherapy.

Treatment
For patients with recurrent osteosarcoma, the most important prognostic factor is surgical resectability. There is a 5-year survival rate of 20% to 45% in patients who had a complete resection of metastatic pulmonary tumors and a 20% survival rate for patients with metastatic tumors at other sites. (25)

Retinoblastoma
Retinoblastoma is the most common primary tumor of the eye in children. It may occur as a heritable (25%-30%) or nonheritable (70%-75%) tumor. (26) Cases may be unilateral or bilateral, with bilateral tumors almost always being the heritable type.

Treatment
Treatment options depend on the extent of disease. Retinoblastoma is usually confined to the eye, and with current therapy, has a high cure rate. However, once disease spreads beyond the eye, survival rates drop significantly; 5-year disease-free survival is reported to be less than 10% in those with extraocular disease, and stage 4B disease (i.e., disease metastatic to the central nervous system) has been lethal in virtually all cases reported. (27)

The strategy for non-metastatic disease depends on the disease extent, but may include focal therapies (e.g., laser photocoagulation, cryotherapy, plaque radiotherapy), intravitreal chemotherapy, intra-arterial chemotherapy, systemic chemotherapy, enucleation, or a combination. (28) For metastatic disease, intensive multimodal therapy with high-dose chemotherapy, with or without radiotherapy, is standard care.

Hematopoietic Cell Transplantation (HCT)
HCT is a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone-marrow-toxic doses of drugs, with or without whole body radiotherapy. Hematopoietic stem cells may be obtained from the transplant recipient (autologous HCT) or a donor (allogeneic HCT). They can be harvested from bone marrow, peripheral blood, or umbilical cord blood shortly after delivery of neonates. Although cord blood is an allogeneic source, the stem-cells in it are antigenically “naive” and thus, are associated with a lower incidence of rejection or graft-versus-host disease.

Immunologic compatibility between infused hematopoietic stem cells and the recipient is not an issue in autologous HCT; however, immunologic compatibility between donor and patient is critical for achieving a good outcome of allogeneic HCT. Compatibility is established by typing of human leukocyte antigens using cellular, serologic, or molecular techniques. Human leukocyte antigens refer to the tissue type expressed at the class I and class II loci on chromosome 6. Depending on the disease being treated, an acceptable donor (except umbilical cord blood) will match the patient at all or most human leukocyte antigens loci.

Regulatory Status
The U.S. Food and Drug Administration regulates human cells and tissues intended for implantation, transplantation, or infusion through the Center for Biologics Evaluation and Research under Code of Federal Regulation, title 21, parts 1270 and 1271. Hematopoietic stem cells are included in these regulations.

Rationale

Medical policies assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life, and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, two domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

PERIPHERAL NEUROBLASTOMA
Single Autologous Hematopoietic Cell Transplantation (HCT)
Clinical Context and Therapy Purpose
The purpose of single autologous HCT is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with high-risk or relapsed peripheral neuroblastoma.

The following PICO was used to select literature to inform this policy.

Populations
The relevant population of interest is individuals with high-risk or relapsed peripheral neuroblastoma.

Interventions
The therapy being considered is single autologous HCT.

Comparators
Comparators of interest include chemotherapy, targeted therapy, surgery, and radiotherapy.

Outcomes
The general outcomes of interest are overall survival (OS), disease-specific survival (DSS), treatment-related mortality (TRM), and treatment-related morbidity.

Follow-up includes the immediate and 12-month posttransplant period to monitor for engraftment and other relevant outcomes. Follow-up will continue to be life-long depending on the success of single autologous HCT.

Study Selection Criteria
Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies;
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought;
- Studies with duplicative or overlapping populations were excluded.

Systematic Reviews
A 2013 Cochrane review evaluated high-dose chemotherapy (HDC) and autologous HCT for high-risk neuroblastomas. (29) Reviewers identified 3 RCTs that included 739 children with high-risk neuroblastoma (Matthay et al. [1999], [30] Berthold et al. [2005], [31] and Pritchard et al. [2005], [32] detailed in the RCT section below). The review was updated in 2015 with no new studies identified, although a manuscript reporting additional follow-up data for one of these RCTs was noted. (33) The primary objective was to compare the efficacy of myeloablative therapy with conventional therapy. Selected studies all used the age of one year as the cutoff point for pretreatment risk stratification. A statistically significant difference in event-free survival (EFS) was observed in favor of myeloablative therapy over conventional chemotherapy or no further treatment (3 studies, 739 patients; hazard ratio [HR], 0.78; 95% confidence interval [CI], 0.67 to 0.90). A statistically significant difference in OS was reported in favor of myeloablative therapy over conventional chemotherapy or no further treatment (2 studies, 360 patients; HR, 0.74; 95% CI, 0.57 to 0.98). When additional follow-up data were included in

analyses, the difference in EFS remained statistically significant (3 studies, 739 patients; HR, 0.79; 95% CI, 0.70 to 0.90), but the difference in OS was no longer statistically significant (2 studies, 360 patients; HR, 0.86; 95% CI, 0.73 to 1.01). Meta-analysis of secondary malignant disease and treatment-related death did not show any statistically significant differences between treatment groups. Data from 1 study (379 patients) showed a significantly higher incidence of renal effects, interstitial pneumonitis, and veno-occlusive disease in the myeloablative group compared with conventional chemotherapy, whereas for serious infections and sepsis, no significant differences between treatment groups were identified. No information on quality of life was reported.

A systematic review by Żebrowska et al. (2024) evaluated the survival benefits of myeloablative therapy (MAT) combined with autologous stem cell transplantation (ASCT) in high-risk neuroblastoma. (34) Analysis of RCTs revealed significant improvements in event-free survival (HR, 0.78; 95% CI, 0.67 to 0.91; p=.001) and a trend toward OS benefit (HR, 0.86; 95% CI, 0.73 to 1.00; p=.05) with MAT+ASCT compared to conventional chemotherapy or no further treatment. Tandem MAT+ASCT demonstrated superior EFS and OS compared to single ASCT, particularly when followed by anti-disialoganglioside 2 immunotherapy. Limited evidence suggested an increased risk of relapse when MAT+ASCT was omitted prior to anti-GD2 therapy, while MAT+ASCT also appeared to improve OS in relapsed patients, though data were sparse.

Randomized Controlled Trials

Three well-designed, RCTs have assessed autologous HCT in the treatment of high-risk neuroblastoma. Matthay et al. (1999) randomized 129 children with high-risk neuroblastoma to a combination of myeloablative chemotherapy, total body irradiation, and transplantation of autologous bone marrow and compared their outcomes with those of 150 children randomized to intensive nonmyeloablative chemotherapy; both groups underwent a second randomization to receive subsequent 13-cis-retinoic acid (cis-RA) or no further therapy. (30) The 3-year EFS rate among patients assigned to transplantation was 43% versus 27% among those assigned to continuation chemotherapy (p=0.027). However, OS rates for both groups did not differ significantly, with 3-year estimates of 43% or 44% for those assigned to transplant and continued chemotherapy, respectively (p=0.87).

Long-term results from this trial were reported in 2009 after a median follow-up of 7.7 years (range, 130 days to 12.8 years). (35) The five-year EFS for patients who underwent autologous transplant was 30% versus 19% for those who underwent nonmyeloablative chemotherapy (p=0.04). Five-year OS rates from the second randomization of patients who underwent both random assignments were 59% for autologous transplant/cis-RA, 41% for autologous transplant/no cis-RS, and, for nonmyeloablative chemotherapy, 38% and 36% with and without cis-RA. Authors concluded that myeloablative chemotherapy and autologous HCT resulted in significantly better 5-year EFS and OS rates.

Berthold et al. (2005) randomized 295 patients with high-risk neuroblastoma to myeloablative therapy (melphalan, etoposide, carboplatin) plus autologous HCT or oral maintenance chemotherapy plus cyclophosphamide. (31) The primary end point was EFS, with secondary

endpoints of OS and treatment-related deaths. Intention-to-treat (ITT) analysis showed that patients who received the myeloablative therapy had an increased 3-year EFS rate compared with the oral maintenance group (47% [95% CI, 38% to 55%] versus 31% [95% CI, 23% to 39%]), but did not have significantly increased 3-year OS rate (62% [95% CI, 54% to 70%] vs 53% [95% CI, 45% to 62%]; p=0.088). Two patients died from therapy-related complications during induction; no patients who received oral maintenance therapy died from treatment-related toxicity, and five patients who received myeloablative therapy died from acute complications related to the therapy.

Pritchard et al. (2005) reported the results of a randomized, multicenter trial that involved 167 children with stage 3 or 4 neuroblastoma treated with standard induction chemotherapy who then underwent surgical resection of their tumor. (32) Sixty-nine percent (n=90) of the patients who achieved complete response (CR) or partial response (PR) to the induction chemotherapy were eligible for randomization to HDC containing melphalan plus autologous HCT or to no further treatment. Seventy-two percent (n=65) of the eligible children were randomized, with 21 surviving at the time of the analysis (median follow-up, 14.3 years). A significant difference in the 5-year EFS and OS rates were seen in children older than 1 year of age with stage 4 disease (48 children with stage 4; 5-year EFS, 33% for HDC vs 17% for no further treatment; p=0.01).

Observational Studies

The use of HCT in patients with high-risk neuroblastoma has been supported in clinical practice. For example, Proust-Houdemont et al. (2016) reported on a 30-year single-center series including 215 patients with stage 4, high-risk neuroblastoma treated with HDC (busulfan) with HCT. (36) In this cohort, 5-year EFS and OS rates were 35.1% and 40%, respectively, and improved from baseline to the end of reporting period. In addition, Giardino et al. (2020) reported results of a retrospective series of 28 patients with relapsed or refractory neuroblastoma who received metaiodobenzylguanidine and high-dose busulfan and melphalan with autologous HCT. (37) After a median follow-up of 15.9 years, OS at 3 and 5 years was 53% and 41%, respectively, and rates of cumulative risk of progression/relapse at 3 and 5 years were 64% and 73%, respectively.

Tandem Autologous HCT

Clinical Context and Therapy Purpose

The purpose of tandem autologous HCT is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with high-risk or relapsed peripheral neuroblastoma.

The following PICO was used to select literature to inform this policy.

Populations

The relevant population of interest is individuals with high-risk or relapsed peripheral neuroblastoma.

Interventions
The therapy being considered is tandem autologous HCT.

Comparators
Comparators of interest include chemotherapy, single autologous HCT, targeted therapy, surgery, and radiotherapy.

Outcomes
The general outcomes of interest are OS, DSS, TRM, and treatment-related morbidity.

Follow-up includes the immediate and 12-month posttransplant period to monitor for engraftment and other relevant outcomes. Follow-up at 24-, 38-, 56-, and 108-months is of interest for tandem autologous HCT to monitor relevant outcomes.

Study Selection Criteria
Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies;
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought;
- Studies with duplicative or overlapping populations were excluded.

Randomized Controlled Trial
Park et al. (2019) conducted an RCT to compare the effects of single versus tandem autologous HCT in patients with high-risk neuroblastoma. (38) A total of 652 eligible patients were enrolled, of which 355 patients (median age at diagnosis, 36.1 months) were randomized to tandem transplant with thiotepa/cyclophosphamide followed by dose-reduced carboplatin/etoposide/ melphalan (n=176) or single transplant with carboplatin/etoposide/melphalan (n=179). Three-year EFS from the time of randomization was 61.6% (95% CI, 54.3% to 68.9%) in the tandem transplant group versus 48.4% (95% CI, 41.0% to 55.7%) in the single transplant group (1-sided log-rank p=.006). The median duration of follow-up after randomization for 181 patients without an event (relapse, progression, secondary malignancy, or death from any cause) was 5.6 years (range, 0.6 to 8.9). The most commonly reported grade 3 or higher toxicities following tandem versus single transplant were mucosal (11.7% vs. 15.4%) and infectious (17.9% vs. 18.3%).

Nonrandomized Comparative Studies
Yan et al. (2022) retrospectively assessed the efficacy of autologous HCT in 90 patients with high-risk neuroblastoma and also compared the prognoses of single versus tandem transplant in these patients. (39) The median patient age at diagnosis was 42 months (range, 11 to 97) and the median follow-up time was 29 months (range, 5 to 78). Three-year EFS and OS rates for the HCT group (n=59) compared with the non-HCT group (n=31) were 65.5% versus 41.3% (p=.023)

and 77.1% versus 57.9% (p=.03), respectively. There were no statistically significant differences between the single transplant group (n=43) and the tandem transplant group (n=16) in the baseline characteristics and treatment response (p>.05). In the tandem versus single transplant group, the 3-year EFS was 51.9% compared with 73.8% (p=.44), respectively, and the 3-year OS was 71.4% compared with 83.4% (p=.73), respectively.

Sung et al. (2010) reported on a retrospective analysis of the efficacy of single versus tandem autologous HCT in patients older than 1 year of age newly diagnosed with stage 4 neuroblastoma from 2000 to 2005 who were enrolled in the Korean Society of Pediatric Hematology-Oncology registry. (40) Patients were intended to receive a single (n=70) or tandem (n=71) autologous HCT at diagnosis; 57 and 59 patients underwent single and tandem transplantation as scheduled, respectively. Between groups, patient characteristics were similar with the exception of a higher proportion in the tandem group having bone metastases. Median follow-up was 56 months (range, 24-88 months) from diagnosis. Transplant-related mortality occurred in 9 patients in the single transplant group and 8 in the tandem group (2 after the first transplant and 6 after the second). The intention-to-treat 5-year EFS rates for single versus tandem was 31.3% and 51.2%, respectively (p=0.03). When the survival analysis only included patients who proceeded to transplant, the probability of relapse-free survival after the first transplant was higher in the tandem group (59.1%) than the single group (41.6%, p=0.099). The difference was statistically significant when the analysis focused on patients who did not achieve a CR before the first transplant (55.7% versus 0%, p=0.012). The authors concluded that tandem HCT for high-risk neuroblastoma is superior to single HCT regarding survival, particularly in patients without CR before HCT.

Ladenstein et al. (2008) reported on more than 4000 transplants for primary (89%) and relapsed (11%) neuroblastoma over 28 years in 27 European countries in the European Group for Blood and Marrow Transplantation registry. (41) Procedures included single autologous (n=2895), tandem autologous (n=455), and allogeneic HCT (n=71). Median age at the time of transplantation was 3.9 years (range, 0.3-62 years), with 77 patients older than age 18 years. Median follow-up from HCT was 9 years. Transplant-related mortality decreased over time in registry patients who only received autologous transplants. Five-year OS rates were 37% for the autologous groups (single and tandem) and 25% for the allogeneic group. Five-year OS rates for single versus tandem autologous HCT were 38% and 33%, respectively (p=0.105).

Single-Arm Studies

George et al. (2006) reported on a 4-institution, single-arm clinical trial to evaluate tandem autologous HCT in pediatric patients with high-risk neuroblastoma (n=82) enrolled between 1994 and 2002. (42) Median age at diagnosis was 35 months (range, 6 months to 18 years). Three- and 5-year OS rates were 74% (95% CI, 62% to 82%) and 64% (95% CI, 52% to 74%), respectively.

Kletzel et al. (2002) reported on a single-center pilot study evaluating the outcomes for 25 consecutive newly diagnosed high-risk neuroblastoma patients and one with recurrent disease treated with triple-tandem autologous HCT. (43) After stem-cell rescue, patients were treated

with radiotherapy to the primary site. Twenty-two of the 26 patients successfully completed induction therapy and were eligible for the triple-tandem consolidation high-dose therapy. Seventeen patients completed all 3 cycles of high-dose therapy and stem-cell rescue, 2 patients completed 2 cycles, and 3 patients completed 1 cycle. One toxicity-related death occurred, and 1 patient died from complications of graft failure. Median follow-up was 38 months, and the 3-year EFS and OS rates were 57% and 79%, respectively.

Grupp et al. (2000) reported on outcomes for a phase 2 trial involving 55 children with high-risk neuroblastoma who underwent tandem autologous HCT. (44) Five patients completed the first HCT course but not the second. There were 4 toxicity-related deaths. With a median follow-up of 24 months from diagnosis, 3-year EFS was 59%.

Case Series

In a retrospective analysis of prospectively collected data, Pasqualini et al. (2016) reported on a series of 26 patients with very high-risk neuroblastoma treated with tandem autologous HCT from 2004 to 2011 at a single center. (45) Criteria for "very high-risk" included stage 4 neuroblastoma at diagnosis or relapse, age over 1 year at diagnosis, less than a partial response of metastases, and more than 3 metaiodobenzylguanidine spots after 2 lines of conventional chemotherapy in patients under 10 years old or no CR of metastases after 1 line of conventional chemotherapy in patients over 10 years old. Median age was 4.4 years (range, 1-15.9 years). Of the 26 patients, 22 were stage 4 at diagnosis; 4 patients had a stage 3 tumor at diagnosis and a metastatic relapse. Three-year EFS and OS rates after diagnosis were 37.3% (95% CI, 21.3% to 56.7%) and 69.0% (95% CI, 49.7% to 83.4%), respectively.

Kim et al. (2007) retrospectively analyzed 36 patients with high-risk (stage 3 or 4) neuroblastoma who underwent a single autologous HCT (n=27) or a tandem autologous HCT (n=9) at a children's hospital in Seoul, Korea, between 1996 and 2004. (46) Disease-free survival (DFS) of patients who underwent double HCT was similar to that of those who underwent a single autologous HCT (p=0.5).

Marcus et al. (2003) reported on outcomes for 52 children with stage 4 or high-risk stage 3 neuroblastoma treated with induction chemotherapy, surgical resection of the tumor when feasible, local radiotherapy, and consolidation with tandem autologous HCT. (47) Radiotherapy was given if gross or microscopic residual disease was present before the myeloablative cycles (n=37). Of the 52 consecutively treated patients analyzed, 44 underwent both transplants, 6 underwent a single transplant, and 2 progressed during induction. The 3-year EFS was 63%, with a median follow-up of 29.5 months.

von Allmen et al. (2005) reported on a retrospective series from the same center as Marcus et al. (2003), with some overlap in patients. (48) The updated series included 76 patients with previously untreated high-risk stage 3 or 4 neuroblastoma treated with aggressive surgical resection with or without local radiotherapy followed by tandem autologous HDC and stem cell rescue. Overall EFS for the series was 56%.

Section Summary: Single Autologous and Tandem HCT for Peripheral Neuroblastoma
Randomized trials comparing single autologous HCT with conventional chemotherapy have reported EFS rates for the patients who underwent HCT ranging from 43% to 47% at 3 years and 30% at 5 years. Case series on the use of tandem autologous HCT for high-risk neuroblastoma have reported 3-year EFS rates ranging from 57% to 63%. A retrospective analysis of a registry of patients with newly diagnosed high-risk neuroblastoma reported 5-year EFS rates for single and tandem autologous HCT of 31% and 51%, respectively (p=0.03). Another more recent retrospective analysis did not show statistically significant differences between single and tandem autologous HCT in treatment response, 3-year EPS, and OS. An RCT found that tandem autologous HCT resulted in statistically significantly better EFS compared with single HCT; however, since the study had a low randomization rate, the findings may not be representative of all patients with high-risk neuroblastoma.

EWING SARCOMA FAMILY OF TUMORS
Single Autologous HCT
Clinical Context and Therapy Purpose
The purpose of single autologous HCT is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with high-risk Ewing sarcoma/Ewing sarcoma family of tumors (ESFT).

The following PICO was used to select literature to inform this policy.

Populations
The relevant population of interest is individuals with high-risk Ewing sarcoma/ESFT.

Interventions
The therapy being considered is single autologous HCT.

Comparators
Comparators of interest include chemotherapy, surgery, and radiotherapy.

Outcomes
The general outcomes of interest are OS, DSS, TRM, and treatment-related morbidity.

Follow-up includes the immediate and 12-month posttransplant period to monitor for engraftment and other relevant outcomes. Follow-up will continue to be life-long depending on the success of single autologous HCT.

Study Selection Criteria
Methodologically credible studies were selected using the following principles:
- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies;

- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought;
- Studies with duplicative or overlapping populations were excluded.

Randomized Controlled Trials

Ladenstein et al. (2010) reported on patients with primary disseminated multifocal Ewing sarcoma (PDMES) who were included in the Euro-EWING 99 trial. (49) From 1999 to 2005, 281 patients with PDMES were enrolled in the Euro-EWING 99 R3 study; the Euro-EWING 99 committee stopped enrollment to this group and released the data. The median age was 16.2 years (range, 0.4-49 years). Patients with isolated lung metastases were not part of the analysis. The recommended treatment consisted of induction chemotherapy, HDC, autologous HCT, and local treatment to the primary tumor (surgery and/or radiation or neither). Induction therapy was completed by 250 (89%) patients. One hundred sixty-nine (60%) of the patients proceeded to HCT. One patient died during induction therapy from sepsis. HDC TRM consisted of 3 patients dying within the first 100 days after high-dose therapy, 1 from acute respiratory distress syndrome and 2 from severe veno-occlusive disease and septicemia; late deaths included 3 patients who died 1 to 1.5 years after high-dose therapy. After a median follow-up of 3.8 years, the estimated 3-year EFS and OS rates for all 281 patients were 27% and 34%, respectively. The international Ewing 2008 trial succeeded the Euro-EWING 99 study in some countries. (50) The Ewing 2008 trial contained an R2Pulm arm for patients with isolated pulmonary metastases (Tables 5 and 6). The primary objective in R2Pulm was to evaluate whether consolidation with HDC plus autologous HCT (n=144) improved EFS compared with consolidation with standard chemotherapy plus whole lung irradiation (n=143). Dirksen et al. (2019) reported on the results of this trial, which found no statistically significant difference in EFS between treatment groups. Nine patients died in the HDC plus autologous HCT group (6 of these deaths were treatment-related and 3 were either due to secondary malignancy, another cause, or unknown cause), and 2 died after standard chemotherapy plus whole lung irradiation (1 death was treatment-related and 1 was due to another cause). Severe acute toxicities were also more prevalent in the group who received HDC plus autologous HCT.

Table 5. Summary of Key RCT Characteristics

Study; Trial	Countries	Sites	Dates	Participants	Interventions	
					Active	**Comparator**
Dirksen (2019); R2Pulm (50)	U.S., EU	144	December 2015 to February 2020	N=267 patients <50 years of age	n=144; HDC plus autologous HCT	n=143; 7 courses of standard chemotherapy plus whole lung irradiation

EU: European Union; HCT: hematopoietic cell transplantation; HDC: high-dose chemotherapy; N: number; RCT: randomized controlled trial; U.S.: United States.

Table 6. Summary of Key RCT Results

Study; Trial	EFS[1] (3 years)	EFS[1] (8 years)	Mortality
Dirksen (2019); R2Pulm (50)			
N	287	287	287
HDC plus autologous HCT	56.6%	52.9%	9/144
Standard chemotherapy plus whole lung irradiation	50.6%	43.1%	2/143
Adjusted HR (95% CI)		0.81 (0.58 to 1.12)	

CI: confidence interval; EFS: event-free survival; HCT: hematopoietic cell transplantation; HDC: high-dose chemotherapy; HR: hazard ratio; N: number; RCT: randomized controlled trial.
[1] Intention-to-treat analysis

Tables 7 and 8 summarize study relevance, conduct, and design limitations.

Table 7. Study Relevance Limitations

Study; Trial	Population[a]	Intervention[b]	Comparator[c]	Outcomes[d]	Duration of Follow-up[e]
Dirksen (2019); R2Pulm (50)	4. Only included patients with Ewing sarcoma and lung metastases				

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Population key: 1. Intended use population unclear; 2. Study population is unclear; 3. Study population not representative of intended use; 4, Enrolled populations do not reflect relevant diversity; 5. Other.
[b] Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest (e.g., proposed as an adjunct but not tested as such); 5: Other.
[c] Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively; 5. Other.
[d] Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. Incomplete reporting of harms; 4. Not establish and validated measurements; 5. Clinically significant difference not prespecified; 6. Clinically significant difference not supported; 7. Other.
[e] Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms; 3. Other.

Table 8. Study Design and Conduct Limitations

Study; Trial	Allocation[a]	Blinding[b]	Selective Reporting[c]	Data Completeness[d]	Power[e]	Statistical[f]
Dirksen (2019); R2Pulm (50)		1, 2: Open-label study			4. Recruitment was stopped	

					before the estimated sample size target was reached due of low accrual	

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

[a] Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias; 5. Other.

[b] Blinding key: 1. Participants or study staff not blinded; 2. Outcome assessors not blinded; 3. Outcome assessed by treating physician; 4. Other.

[c] Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication; 4. Other.

[d] Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials); 7. Other.

[e] Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference; 4. Other.

[f] Statistical key: 1. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated; 5. Other.

Single-Arm Studies

Subsequently, Meyers et al. (2001) reported on a prospective study with autologous HCT in 32 patients with newly diagnosed Ewing sarcoma metastatic to bone and/or bone marrow. Induction therapy consisted of 5 cycles of cyclophosphamide-doxorubicin-vincristine, alternating with ifosfamide-etoposide. (51) Twenty-three patients proceeded to the consolidation phase with melphalan, etoposide, total body irradiation, and autologous HCT (of the 9 patients who did not proceed, 2 were secondary to toxicity and 4 to progressive disease). Three patients died during the HDC phase. Two-year EFS for all eligible patients was 20% and 24% for the 29 patients who received the high-dose consolidation therapy. Trialists concluded that consolidation with HDC, total body irradiation, and autologous stem cell support failed to improve EFS for this cohort of patients compared with a similar group of patients treated with conventional therapy. Authors noted that their findings differed from some previous studies, and that the previous studies were limited by the inclusion of heterogeneous patient populations. They concluded that future trials of autologous HCT must be conducted prospectively, identify a group at high-risk for failure, and enroll all patients in the study at the same point in therapy.

Gardner et al. (2008) reported on the results of 116 patients with Ewing sarcoma who underwent autologous HCT (80 as first-line therapy, 36 for recurrent disease) between 1989 and 2000. (52) Five-year rates of PFS in patients who received HCT as first-line therapy were 49% (95% CI, 30% to 69%) for those with localized disease at diagnosis and 34% (95% CI, 22% to

47%) for those with metastatic disease at diagnosis. For the population with localized disease at diagnosis and recurrent disease, the 5-year probability of PFS was 14% (95% CI, 3% to 30%). The authors concluded that PFS rates after autologous HCT were comparable with rates seen in patients with similar disease characteristics treated with conventional therapy.

Lee et al. (2025) published the retrospective results of 20 patients who received HDC/HCT for high-risk Ewing sarcoma. (53) The mean age of the included patients was 15.6 years and all transplants were successfully engrafted. Outcomes included CR in 6 patients, PR in 13 patients, and stable disease in 1 patient. Five-year OS and PFS were 54.5% and 35%, respectively. The authors reported that the OS rate was higher than a historical cohort who did not receive HDC/HCT (p=.018).

Case Series

During the 1980s and 1990s, several small series, case reports, and a report from the European Bone Marrow Transplant Registry suggested that autologous HCT could improve outcomes for patients with high-risk ESFT. (54) These early results supported the use of HCT for high-risk ESFT.

Tandem Autologous HCT

Clinical Context and Therapy Purpose

The purpose of tandem autologous HCT is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with high-risk Ewing sarcoma/ESFT.

The following PICO was used to select literature to inform this policy.

Populations

The relevant population of interest is individuals with high-risk Ewing sarcoma/ESFT.

Interventions

The therapy being considered is tandem autologous HCT.

Comparators

Comparators of interest include chemotherapy, single autologous HCT, surgery, and radiotherapy.

Outcomes

The general outcomes of interest are OS, DSS, TRM, and treatment-related morbidity.

Follow-up includes the immediate and 12-month posttransplant period to monitor for engraftment and other relevant outcomes. Follow-up will continue to be life-long depending on the success of single autologous HCT.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies;
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought;
- Studies with duplicative or overlapping populations were excluded.

Case Series

Loschi et al. (2015) reported on a series of 18 patients with PDMES under age 25 treated with tandem HCT at a single institution from 2002 to 2009. (55) Of the 18 patients with PDMES planned for tandem HCT, 15 (83%) received the first HCT, and 13 (72%) received the full-tandem HCT program due to progressive disease before stem cell harvest could be obtained. Eleven patients had no disease progression by the end of the HCT program, but 9 of the 11 had relapsed at a median delay of 6.2 months (range, 2.5-14.1 months). Median EFS and OS rates were 13.5 and 17.3 months, respectively.

Section Summary: Single Autologous and Tandem HCT for ESFT

Studies of HCT in patients with ESFT are characterized by small numbers of patients and comparisons across studies were difficult for several reasons. Within each report, patients could have received a variety of chemotherapeutic regimens, and many studies did not share the same patient eligibility criteria (and in some, the definition of high-risk included patients with criteria that did not result in inferior prognosis). Also, some studies used allogeneic HCT. The risk-adjusted system used in Euro-EWING 99 may allow the best selection of patients appropriate for treatment. The international Ewing 2008 trial succeeded the Euro-EWING 99 study in some countries. The Ewing 2008 trial contained an R2Pulm arm for patients with Ewing sarcoma and pulmonary and/or pleural metastases. The R2Pulm RCT compared consolidation with HDC plus autologous HCT to standard chemotherapy plus whole lung irradiation and did not find a significant EFS advantage with either treatment.

RHABDOMYOSARCOMA

Clinical Context and Therapy Purpose

The purpose of single autologous HCT is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with rhabdomyosarcoma (RMS).

The following PICO was used to select literature to inform this policy.

Populations

The relevant population of interest is individuals with RMS.

Interventions

The therapy being considered is single autologous HCT.

Comparators

Comparators of interest include chemotherapy, surgery, and radiotherapy.

Outcomes
The general outcomes of interest are OS, DSS, TRM, and treatment-related morbidity.

Follow-up includes the immediate and 12-month posttransplant period to monitor for engraftment and other relevant outcomes. Follow-up will continue to be life-long depending on the success of single autologous HCT.

Study Selection Criteria
Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies;
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought;
- Studies with duplicative or overlapping populations were excluded.

Systematic Review
Weigel et al. (2001) reviewed and summarized published evidence on the role of autologous HCT in the treatment of metastatic or recurrent RMS from 22 studies (N=389 patients). (56) Based on all of the evidence analyzing EFS and OS rates, they concluded that there was no significant advantage in undergoing HDC with HCT in patients with relapsed or refractory high-risk RMS.

Nonrandomized Comparative Studies
McDowell et al. (2010) reported on the results of the International Society of Paediatric Oncology study MMT-98; pediatric patients from 48 centers with metastatic RMS entered into the study from 1998 to 2005. (57) A total of 146 patients enrolled (age range, 6 months to 18 years). Patients were risk-stratified and treated accordingly. One hundred one patients were stratified as poor-risk (poor-risk group [PRG]), defined as being older than 10 years of age or having bone marrow or bone metastases. Planned therapy for the PRG was induction therapy, sequential HDC, peripheral blood autologous HCT, and maintenance therapy. Seventy-nine (78.2%) of the 101 PRG patients underwent the high-dose therapy, after which 67.1% achieved a PR or CR. Sixty-seven of the 101 poor-risk patients received local treatment: 37 received radiotherapy alone, 10 received surgery alone, and 20 received both modalities. No treatment-related deaths were reported in the PRG. Three- and 5-year EFS rates for the PRG were 16.5% and 14.9%, respectively, with 3- and 5-year OS rates of 23.7% and 17.9%, respectively (HR, 2.46; 95% CI, 1.51 to 4.03; $p<0.001$).

Klingebiel et al. (2008) prospectively compared the efficacy of 2 HDC treatments followed by autologous stem cell rescue with an oral maintenance treatment (OMT) in 96 children with stage 4 soft tissue sarcoma (88 of whom had RMS). (58) Five-year OS probability for the whole

group was 0.52 (standard deviation [SD], 0.14) for the patients who received OMT (n=51) and 0.27 (SD, 0.13) for the transplant group (n=45; p=0.03). For the patients with RMS, 5-year OS probability was 0.52 (SD, 0.16) with OMT and 0.15 (SD, 0.12) with transplant (p=0.001). The authors concluded that transplant failed to improve prognosis in metastatic soft tissue sarcoma, but that OMT could be a promising alternative.

Carli et al. (1999) conducted a prospective nonrandomized study of 52 patients with metastatic RMS who were in CR after induction therapy and subsequently received HDC (megatherapy) and autologous HCT and compared them to 44 patients who were in remission after induction therapy who subsequently received conventional chemotherapy. (59) No significant differences existed between groups (i.e., clinical characteristics, induction chemotherapy received, sites of primary tumor, histologic subtype, age, presence/extent of metastases). Three-year EFS and OS rates were 29.7% and 40%, respectively, for the autologous HSCT group and 19.2% and 27.7%, respectively, for the chemotherapy group. Differences were not statistically significant for EFS (p=0.3) or OS (p=0.2). Median time to relapse after chemotherapy was 168 days for the autologous HCT group and 104 days for the standard chemotherapy group (p=0.05). Although the use of autologous HCT delayed time to relapse, there was no clear survival benefit compared with conventional chemotherapy.

Section Summary: Rhabdomyosarcoma

Autologous HCT has been evaluated in a limited number of patients with high-risk RMS (stage 4 or relapsed) in whom CR was achieved after standard induction therapy. The evidence is relatively scarce, due in part to the rarity of the condition. The role of stem cell transplantation of any type for this cancer has not been established.

WILMS TUMOR

Clinical Context and Therapy Purpose

The purpose of single autologous HCT is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with Wilms tumor.

The following PICO was used to select literature to inform this policy.

Patients

The relevant population of interest is individuals with Wilms tumor.

Interventions

The therapy being considered is single autologous HCT.

Comparators

Comparators of interest include chemotherapy, surgery, and radiotherapy.

Outcomes

The general outcomes of interest are OS, DSS, TRM, and treatment-related morbidity.

Follow-up includes the immediate and 12-month posttransplant period to monitor for engraftment and other relevant outcomes. Follow-up will continue to be life-long depending on the success of single autologous HCT.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies;
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought;
- Studies with duplicative or overlapping populations were excluded.

Meta-analysis

A 2010 individual patient data meta-analysis reported on the efficacy of autologous HCT in recurrent Wilms tumor for studies published between 1984 and 2008 that reported survival data. (60) Six studies were included (N=100 patients). (22, 61-65) Patient characteristics and treatment methods were similar across studies, although there was variation in the preparative regimens used. Patients were between the ages of 11 months and 16 years and had similar primary tumor stage, relapse location, and time to relapse. The 4-year OS rate among the 100 patients was 54.1% (95% CI, 42.8%-64.1%), and the 4-year EFS rate (based on 79 patients) was 50.0% (95% CI, 37.9%-60.9%). In multivariate analysis, site of relapse and histology were important predictors for survival; patients who did not have a lung-only relapse were at approximately 3 times higher risk of death or recurrence (HR, 3.5) than patients who relapsed in the lungs only (HR, 2.4), and the patients with unfavorable histology had approximately twice the risk of death compared with those with favorable histology. For all 6 studies, reviewers compared the survival rates for patients who received autologous HCT with patients who received conventional chemotherapy. In general, the chemotherapy-treated patients had similar or improved 4-year survival rates compared with the HCT group; however, there was a suggestion that patients with lung-only stage 3 and 4 relapses could benefit from autologous HCT; they had a 21.7% survival advantage over chemotherapy (however, the CI ranges were very wide): 4-year OS rates for the stage 3 and 4 patients with lung only relapse treated with HCT were 74.5% (95% CI, 51.7% to 87.7%) and 52.8% (95% CI, 29.7% to 71.5%) for chemotherapy.

Retrospective Studies

Delafoy et al. (2022) published a retrospective analysis describing the outcomes of 54 patients with Wilms tumor in France who received HDC plus autologous HCT as first-line treatment or following disease recurrence between 2000 and 2016. (66) The 5-year estimates for EFS and OS in patients receiving first-line treatment were 54% (95% CI, 32% to 76%) and 62% (95% CI, 31% to 82%), respectively. The 5-year estimates for EFS and OS in patients receiving treatment following disease recurrence were 57% (95% CI, 39% to 71%) and 69% (95% CI, 52% to 81%), respectively. Treatment-related death occurred in 3 patients.

Malogolowkin et al. (2017) published a retrospective analysis describing the outcomes of 253 patients with relapsed Wilms tumor who received HDC followed by autologous HCT between 1990 and 2013 that were reported to the Center for International Blood and Marrow Transplant Research. (67) The 5-year estimates for EFS and OS were 36% (95% CI, 29%-43%) and 45% (95% CI, 38%-51%), respectively. Relapse of primary disease was the cause of death in 81% of the population. EFS, OS, relapse, and transplant-related mortality showed no significant differences when broken down by disease status at transplant, time from diagnosis to transplant, year of transplant, or conditioning regimen. The data suggest that HDC followed by autologous HCT for relapsed Wilms tumor is well tolerated and outcomes are similar to those reported in the literature. The greatest limitation of the study is its retrospective design (registry-based analyses) and that the data originated from basic forms, and thus, did not include information on histology, site of metastases, stage of disease, genetic syndrome, tumor spillage, and radiation.

Section Summary: Wilms Tumor

The evidence on the use of autologous HCT for high-risk Wilms tumor consists of retrospective studies and an individual patient data meta-analysis. For some subgroups, particularly patients with lung-only stage 3 and 4 relapses, some analyses suggested that HCT could be associated with a survival benefit.

OSTEOSARCOMA

Clinical Context and Therapy Purpose

The purpose of single autologous HCT is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with osteosarcoma.

The following PICO was used to select literature to inform this policy.

Populations

The relevant population of interest is individuals with osteosarcoma.

Interventions

The therapy being considered is single autologous HCT.

Comparators

Comparators of interest include chemotherapy, surgery, and radiotherapy.

Outcomes

The general outcomes of interest are OS, DSS, TRM, and treatment-related morbidity.

Follow-up includes the immediate and 12-month posttransplant period to monitor for engraftment and other relevant outcomes. Follow-up will continue to be life-long depending on the success of single autologous HCT.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies;
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought;
- Studies with duplicative or overlapping populations were excluded.

Prospective and Retrospective Studies

Hong et al. (2022) retrospectively evaluated 113 patients with nonmetastatic osteosarcoma. (68) The median patient age at diagnosis was 12.6 years (range, 5.0 to 20.3 years). All patients received neoadjuvant chemotherapy, which was continued when the postoperative necrosis rate was more than 90% (good response), whereas most cases with less than 90% (poor response) were changed to chemotherapy (either adjuvant conventional chemotherapy or HDC [melphalan/etoposide/carboplatin] with autologous HCT). In patients with poor response (n=44), the 5-year EFS rates of the HDC plus HCT group (n=24) compared with conventional chemotherapy (n=20) were 78.6% (95% CI, 61.9% to 95.3%) and 53.6% (95% CI, 31.1% to 76.1%; p=.065), respectively, and the 5-year OS rates were 100% and 76.9% (95% CI, 56.7% to 97.1%; p=.024), respectively. A limitation of the study is that it was a retrospective analysis that included patients who received heterogeneous chemotherapies. The study authors also acknowledged that previous studies, including the Venkatramani et al. (2016) prospective study summarized below, (69) did not find improved outcomes with HDC with HCT. However, this study is different from previous studies in the regimen used (melphalan/etoposide/carboplatin) and in analyzing only patients with nonmetastatic osteosarcoma who showed low-degree necrosis following neoadjuvant chemotherapy.

Venkatramani et al. (2016) reported on outcomes from a protocol in which patients with newly diagnosed, biopsy-proven high-grade osteosarcoma with less than 90% tumor necrosis after preoperative chemotherapy were treated with 3 courses of HDC plus autologous HCT. (69) The single-arm study enrolled 52 patients with localized osteosarcoma, most commonly of the femur (52%) from 1999 to 2006 who underwent definitive surgery; 6 patients withdrew prior to surgery, and 6 after surgery. Under the study's initial protocol, those with less than 90% tumor necrosis were intended for HCT following HDC with melphalan and cyclophosphamide, and those with good tumor response were allocated to standard chemotherapy. However, after the first 18 patients received HCT, an interim analysis showed a 2-year EFS rate of 41%, which was less than the objective of 75% EFS compared with historical data of 55% by treating 48 patients with non-metastatic disease who showed less than 90% necrosis following preoperative chemotherapy. Subsequently, all patients were enrolled to the standard therapy arm. Forty patients were evaluable after a median follow-up of 39 months. The 5-year EFS and OS rates were 62% (95% CI, 36% to 80%) and 74% (95% CI, 44% to 90%), respectively, for patients treated in the standard chemotherapy arm. The 5-year EFS and OS rates were 28% (95% CI, 10% to 49%) and 48% (95% CI, 23% to 69%), respectively, for patients treated in the HCT arm.

Case Series

Hong et al. (2015) reported on a series of 19 patients with high-risk osteosarcoma treated with autologous HCT at a single center from 2006 to 2013. (70) Median age at diagnosis was 11.8 years (range, 5.4-15.7 years). The indications for HCT were tumor necrosis less than 90% (n=8), initial metastasis (n=2), relapse (n=2), or a combination of tumor necrosis less than 90%, initial metastasis, and/or progression (n=6). At a mean follow-up of 31 months (range, 1-91 months), the OS rate was 78.3% and the EFS rate was 67.4%.

Additional small case series and case reports have examined the use of autologous HCT in osteosarcoma. (71, 72) Autologous HCT has been successful in inducing short-lasting remissions but has not shown an increase in survival.

Section Summary: Osteosarcoma

The evidence on the use of autologous HCT for treatment of osteosarcoma is limited to case series, a prospective single-arm study, and a retrospective study. An interim analysis of the single-arm study showed that patients receiving autologous HCT were experiencing lower EFS rates than historical controls, resulting in all patients enrolling in the standard of care chemotherapy arm for the remainder of the study. Conversely, a retrospective study found favorable survival outcomes with HDC plus autologous HCT in patients with nonmetastatic osteosarcoma with low-degree necrosis after neoadjuvant chemotherapy.

RETINOBLASTOMA

Localized Retinoblastoma

Clinical Context and Therapy Purpose

The purpose of single autologous HCT is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with localized retinoblastoma.

The following PICO was used to select literature to inform this policy.

Populations

The relevant population of interest is individuals with localized retinoblastoma.

Interventions

The therapy being considered is single autologous HCT.

Comparators

Comparators of interest include laser photocoagulation, cryotherapy, chemotherapy (local or systemic), surgery, and radiotherapy.

Outcomes

The general outcomes of interest are OS, DSS, TRM, and treatment-related morbidity.

Follow-up includes the immediate and 12-month posttransplant period to monitor for engraftment and other relevant outcomes. Follow-up will continue to be life-long depending on the success of single autologous HCT.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies;
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought;
- Studies with duplicative or overlapping populations were excluded.

No studies focusing on autologous HCT for patients with localized retinoblastoma were identified in literature searches.

Metastatic Retinoblastoma

Clinical Context and Therapy Purpose

The purpose of single autologous HCT is to provide a treatment option that is an alternative to or an improvement on existing therapies in individuals with metastatic retinoblastoma.

The following PICO were used to select literature to inform this policy.

Populations

The relevant population of interest is individuals with metastatic retinoblastoma.

Interventions

The therapy being considered is single autologous HCT.

Comparators

Comparators of interest include chemotherapy, surgery, and radiotherapy.

Outcomes

The general outcomes of interest are OS, DSS, TRM, and treatment-related morbidity.

Follow-up includes the immediate and 12-month posttransplant period to monitor for engraftment and other relevant outcomes. Follow-up will continue to be life-long depending on the success of single autologous HCT.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;

- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies;
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought;
- Studies with duplicative or overlapping populations were excluded.

Prospective and Retrospective Studies

A prospective, international trial assessed the effectiveness of intensive multimodality therapy in patients aged 10 years and younger with extraocular retinoblastoma. (73) Patients with stage 2 or 3 (locoregional) disease received 4 cycles of chemotherapy and radiation therapy. Patients with stage 4A or 4B (metastatic or trilateral) disease received 4 cycles of chemotherapy; those with at least a PR then received 1 cycle of HDC with autologous HCT. The median follow-up was 7.3 years. One-year EFS was 88.1% (90% CI, 66.6% to 96.2%) for stage 2 or 3 disease (n=19), 82.6% (90% CI, 61.0% to 92.9%) for stage 4A disease (n=18), and 28.3% (90% CI, 12.7% to 46.2%) for stage 4B disease (n=20). Recurrences occurred in 2 patients with stage 4A disease at 5 and 9 months, and 10 patients with stage 4B disease at a median of 6 months; all recurrences were in the central nervous system (CNS). The authors concluded that more effective therapy is needed for stage 4B disease (patients with CNS involvement).

Farouk et al. (2022) performed a retrospective analysis of 24 patients with stage 4A metastatic retinoblastoma who underwent HDC plus autologous HCT. (74) All patients experienced hematopoietic recovery post HCT. The median age at diagnosis of stage 4A retinoblastoma and HCT was 2 years (range, 0.1 to 7.4) and 3.7 years (range, 2.3 to 9.8), respectively. The median follow-up time from HCT was 6.3 years (range, 0.4 to 27.7). Kaplan-Meier estimates of 5-year and 10-year OS were 81% ± 8.6% and 59.3% ± 12.4%, respectively, with early deaths due to recurrent retinoblastoma (n=4) and late deaths due to subsequent malignant neoplasms. The authors concluded that intensive multimodality therapy including HDC plus autologous HCT is curative in most patients with stage 4A retinoblastoma.

Case Series

Most studies of autologous HCT for metastatic retinoblastoma have been very small series or case reports. (75-78) More recently, Dunkel et al. (2010) reported on outcomes for 15 consecutive patients with stage 4A metastatic retinoblastoma who presented between 1993 and 2006 and were treated with HDC and autologous HCT. (79) Twelve patients had unilateral retinoblastoma and 3 had bilateral disease. Metastatic disease was not detected at diagnosis but became clinically evident at a median of 6 months (range, 1-82 months) post-enucleation. Patients had metastatic disease to bone marrow (n=14), bone (n=10), the orbit (n=9), and/or the liver (n=4). Two patients progressed before HCT and died. Thirteen patients underwent HCT, and 10 are retinoblastoma-free in first remission at a median follow-up of 103 months (range, 34-202 months). Three patients experienced recurrence 14 to 20 months post-diagnosis of metastatic disease (2 in the CNS, 1 in the mandible), and all died of their disease. Five-year retinoblastoma-free survival and EFS rates were 67% (95% CI, 38% to 85%) and 59% (95% CI, 31% to 79%), respectively. Six of the 10 patients who survived received radiotherapy. Three patients developed secondary osteosarcoma at 4, 9, and 14 years post-diagnosis of metastatic

disease, 2 in previously irradiated fields, and 1 in a nonirradiated field. The authors concluded that HCT was curative for most patients treated in their study with stage 4A retinoblastoma.

Dunkel et al. (2010) also reported on outcomes for 8 patients diagnosed with stage 4B retinoblastoma between 2000 and 2006 treated with the intention of autologous HCT. (27) Seven patients had leptomeningeal disease and 1 had only direct extension to the CNS via the optic nerve. At the time of diagnosis of intraocular retinoblastoma, 3 patients already had stage 4B disease; the other 5 patients developed metastatic disease at a median of 12 months (range, 3-69 months). Two patients progressed before HCT, and 1 patient died due to toxicity during induction chemotherapy. Of the 5 patients who underwent HCT, 2 were event-free at 40 and 101 months. One of the event-free survivors received radiotherapy (external-beam plus intrathecal radioimmunotherapy), and the other did not receive any radiation. Three patients had tumor recurrence at 3, 7, and 10 months post-HCT. The authors concluded that HCT could be beneficial for some patients with stage 4B retinoblastoma, but longer follow-up would be necessary to determine whether it is curative in this population.

Section Summary: Localized and Metastatic Retinoblastoma

There is a lack of evidence evaluating the use of autologous HCT for localized retinoblastoma. The role of stem cell transplantation has not been established in the therapy of patients with localized retinoblastoma.

The results have been promising regarding prolonging EFS and OS in patients with metastatic retinoblastoma, particularly those without CNS involvement (stage 4A). Given that clinical prognosis is very poor for patients with metastases, results showing the survival of some patients for 3 or more years after HCT might provide evidence to demonstrate a benefit in survival.

Comparative Effectiveness Review

The Agency for Healthcare Research and Quality completed a comparative effectiveness review on the use of HCT in the pediatric population. (80) The following conclusions were offered:

- Neuroblastoma: The body of evidence on OS with tandem HCT compared with single HCT for the treatment of high-risk neuroblastoma was insufficient to draw conclusions.
- ESFT: The low-strength evidence on OS suggested no benefit with single HCT compared with conventional therapy for the treatment of high-risk ESFT.
    - The body of evidence on OS with tandem HCT compared with single HCT for the treatment of high-risk ESFT and OS was insufficient to draw conclusions.
- RMS: The moderate-strength evidence on OS suggested no benefit with single HCT compared with conventional therapy for the treatment of high-risk metastatic RMS.
    - The body of evidence on OS with single HCT compared with conventional therapy for the treatment of high-risk RMS of mixed tumor type was insufficient to draw conclusions.
    - The body of evidence on OS with single HCT compared with conventional therapy for the treatment of congenital alveolar RMS, cranial parameningeal RMS with

metastasis or the use of allogeneic transplantation for metastatic RMS was insufficient to draw conclusions.

- Wilms tumor: The low-strength evidence on OS suggested no benefit with single HCT compared with conventional therapy for the treatment of high-risk relapsed Wilms tumor.
- Osteosarcoma was not addressed.
- Retinoblastoma: The low-strength evidence on OS suggested no benefit with single HCT compared with conventional therapy for the treatment of extraocular retinoblastoma with CNS involvement.
    - The body of evidence on OS with single HCT compared with conventional therapy for the treatment of extraocular retinoblastoma without CNS involvement was insufficient to draw conclusions.
    - The body of evidence on OS with single HCT compared with conventional therapy for the treatment of trilateral retinoblastoma without CNS involvement was insufficient to draw conclusions.

Summary of Evidence

Peripheral Neuroblastoma

For individuals who have high-risk or relapsed peripheral neuroblastoma who receive single or tandem autologous hematopoietic cell transplantation (HCT), the evidence includes randomized controlled trials (RCTs), systematic reviews with meta-analyses of those trials, and observational studies. Relevant outcomes are overall survival (OS), disease-specific survival (DSS), and treatment-related mortality (TRM) and morbidity. In the pooled analysis, patients with high-risk neuroblastoma treated with first-line therapy with single autologous HCT with myeloablative conditioning had significantly improved event-free survival (EFS) compared with standard therapy. Similarly, nonrandomized comparative studies, single-arm studies, and case series evaluating tandem autologous HCT showed improvements in EFS for children with high-risk neuroblastoma. A recent RCT found that tandem autologous HCT resulted in statistically significantly better EFS compared with single HCT. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Ewing Sarcoma

For individuals who have high-risk Ewing sarcoma who receive single or tandem autologous HCT, the evidence includes an RCT, single-arm studies, and case series. Relevant outcomes are OS, DSS, and TRM and morbidity. Although early nonrandomized studies were promising, more recent prospective nonrandomized study results have been inconsistent regarding whether HCT extends survival compared with typical conventional therapy. An RCT comparing consolidation with high-dose chemotherapy (HDC) plus autologous HCT to standard chemotherapy plus whole lung irradiation in patients with Ewing sarcoma with pulmonary and/or pleural metastases did not find a significant improvement in EFS in the group that received HCT. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Rhabdomyosarcoma (RMS)

For individuals who have RMS who receive single autologous HCT, the evidence includes a systematic review and nonrandomized comparative studies. Relevant outcomes are OS, DSS, and TRM and morbidity. Available studies have not demonstrated improvements in OS or EFS with autologous HCT. Additional research is needed to demonstrate a benefit with autologous HCT for pediatric RMS. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Wilms Tumor

For individuals with Wilms tumor who receive single autologous HCT, the evidence includes retrospective studies and a meta-analysis. Relevant outcomes are OS, DSS, and TRM and morbidity. In the meta-analysis, overall 4-year survival rates were similar between patients receiving HCT and receiving chemotherapy. There was a trend suggesting that patients with lung-only stage 3 and 4 relapses might benefit from autologous HCT. However, the overall body of evidence is limited. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Osteosarcoma

For individuals who have osteosarcoma who receive single autologous HCT, the evidence includes case series, a prospective single-arm study, and a retrospective study. Relevant outcomes are OS, DSS, and TRM and morbidity. An interim analysis of the prospective single-arm study showed that patients receiving autologous HCT were experiencing lower EFS rates than historical controls, resulting in all patients being enrolled in the standard of care chemotherapy. Conversely, a retrospective study found favorable EFS and OS rates with HDC plus autologous HCT in patients with nonmetastatic osteosarcoma with low-degree necrosis after neoadjuvant chemotherapy. The overall body of evidence is limited. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Localized Retinoblastoma

For individuals who have localized retinoblastoma who receive single autologous HCT, there are no studies. Relevant outcomes are OS, DSS, and TRM and morbidity. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Metastatic Retinoblastoma

For individuals who have metastatic retinoblastoma who receive single autologous HCT, the evidence includes small case series and case reports, and prospective and retrospective studies. Relevant outcomes are OS, DSS, and TRM and morbidity. Results from the limited data have suggested that autologous HCT may prolong EFS and OS, particularly in patients without central nervous system involvement (stage 4A disease). Given the poor prognosis for this indication with conventional therapies, the incremental improvement with autologous HCT might be considered a significant benefit. However, the overall body of evidence is limited. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

2107 Input
For individuals who have metastatic retinoblastoma who receive autologous HCT, clinical input supports this use provides a clinically meaningful improvement in net health outcome and indicates this use is consistent with generally accepted medical practice.

Practice Guidelines and Position Statements
American Society for Transplantation and Cellular Therapy
In 2020, the American Society for Transplantation and Cellular Therapy published consensus guidelines for clinically appropriate indications for HCT based on best prevailing evidence. (81) Indications for HCT in pediatric patients with the solid tumor types addressed in this policy are outlined in Table 9.

Table 9. Indications for HCT in Pediatric Patients with Solid Tumors

Indication and Disease Status	Allogeneic HCT[a]	Autologous HCT[a]
Ewing sarcoma, high-risk or relapse	D	S
Soft tissue sarcoma, high-risk or relapse	D	D
Neuroblastoma, high-risk or relapse	D	S[b]
Wilms tumor, relapse	N	C
Osteosarcoma, high-risk	N	C

Adapted from Kanate et al. (2020). (81)
HCT: hematopoietic cell transplantation.
[a] "Standard of care (S): This category includes indications that are well defined and are generally supported by evidence in the form of high quality clinical trials and/or observational studies (e.g., through CIBMTR or EBMT)." "Standard of care, clinical evidence available (C): This category includes indications for which large clinical trials and observational studies are not available. However, HCT/ immune effector cell therapy (IECT) has been shown to be an effective therapy with acceptable risk of morbidity and mortality in sufficiently large single- or multi-center cohort studies. HCT/IECT can be considered as a treatment option for individual patients after careful evaluation of risks and benefits. As more evidence becomes available, some indications may be reclassified as 'Standard of Care'." "Developmental (D): Developmental indications include diseases where pre-clinical and/or early phase clinical studies show HCT/IECT to be a promising treatment option. HCT/IECT is best pursued for these indications as part of a clinical trial. As more evidence becomes available, some indications may be reclassified as 'Standard of Care, Clinical Evidence Available' or 'Standard of Care'." "Not generally recommended (N): HCT/IECT is not currently recommended for these indications where evidence do not support the routine use of HCT/IECT. However, this recommendation does not preclude investigation of HCT/IECT as a potential treatment and may be pursued for these indications within the context of a clinical trial."
[b] Tandem autologous HCT recommended.

National Comprehensive Cancer Network
Current National Comprehensive Cancer Network (NCCN) guidelines or comments on HCT related to the cancers addressed in this policy are summarized in Table 10. Other tumor types are not addressed in NCCN guidelines.

Table 10. NCCN Guidelines

Year	NCCN Guideline	Tumor Type	NCCN Comments
V2.2026	Bone Cancer (82)	Osteosarcoma	"The safety and efficacy of HDT/HCT in patients with locally advanced, metastatic, or relapsed osteosarcoma have also been evaluated. In the Italian Sarcoma Group study, treatment with carboplatin and etoposide was followed by stem cell rescue, combined with surgery-induced complete response in chemosensitive disease. Transplant-related mortality was 3.1%. The 3-year OS and DFS rates were 20% and 12%, respectively. The efficacy of this approach in patients with high-risk disease is yet to be determined in prospective randomized studies."
V2.2026	Bone Cancer (82)	Ewing Sarcoma	“HDT followed by HCT has been evaluated in patients with localized as well as metastatic disease. HDT/HCT has been associated with potential survival benefit in patients with non-metastatic disease. However, studies that have evaluated HDT/HCT in patients with primary metastatic disease have shown conflicting results…. HDT/HCT has been associated with improved long-term survival in patients with relapsed or progressive Ewing sarcoma in small, single-institution studies. The role of this approach is yet to be determined in prospective randomized studies.”
V2.2026	Soft Tissue Sarcoma (83)	Rhabdomyo-sarcoma	HCT not addressed.
V2.2025	Wilms Tumor (Nephroblastoma) (84)	Wilms tumor	HCT not addressed.
V1.2025	Neuroblastoma (85)	Neuroblastoma	"For patients who are candidates for consolidation therapy, the Panel recommends tandem transplantation with two consecutive rounds of high-dose chemotherapy with autologous

			stem cell rescue for the majority of patients with high-risk disease."

HCT: hematopoietic cell transplantation; HDT: high dose therapy; NCCN: National Comprehensive Cancer Network; OS: overall survival; DFS: disease free survival.

National Ewing Sarcoma Tumor Board

The National Ewing Sarcoma Tumor Board published consensus recommendations for systemic therapies in the management of relapsed Ewing sarcoma. (86) Regarding HCT, the board states that "high-dose therapy with autologous stem cell rescue (HDT) has been attempted for the treatment of patients with Ewing Sarcoma (ES), in both the upfront and relapsed settings. Although HDT has been incorporated into the treatment of patients with high-risk neuroblastoma and high-risk medulloblastoma, its role in the treatment of patients with ES remains controversial."

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this policy are listed in Table 11.

Table 11. Summary of Key Trials

NCT Number	Trial Name	Planned Enrollment	Completion Date
Combined solid tumor			
NCT00638898	Pilot Study of High-Dose Chemotherapy With Busulfan, Melphalan, and Topotecan Followed by Autologous Hematopoietic Stem Cell Transplant in Advanced Stage and Recurrent Tumors	25	Dec 2024
NCT01505569	Alkylator-Intense Conditioning Followed by Autologous Transplantation for Patients With High Risk or Relapsed Solid or CNS Tumors	44	Feb 2024
Peripheral neuroblastoma			
NCT01526603	High Dose Chemotherapy and Autologous Peripheral Blood Stem Cell (PBSC) Rescue for Neuroblastoma: Standard of Care Considerations	13	May 2023
NCT02605421	Tandem Myeloablative Consolidation Therapy and Autologous Stem Cell Rescue for High-Risk Neuroblastoma	12	Dec 2026
NCT01704716	High-Risk Neuroblastoma Study 1 of SIOP-Europe (SIOPEN)	3300	Sep 2026
NCT06172296	A Phase 3 Study of Dinutuximab Added to Intensive Multimodal Therapy for Children With Newly Diagnosed High-Risk Neuroblastoma	478	Dec 2029

NCT: national clinical trial.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	36511, 38204, 38205, 38206, 38207, 38208, 38209, 38210, 38211, 38212, 38213, 38214, 38215, 38220, 38221, 38222, 38230, 38232, 38240, 38241, 38242, 38243, 81265, 81266, 81267, 81268, 81370, 81371, 81372, 81373, 81374, 81375, 81376, 81377, 81378, 81379, 81380, 81381, 81382, 81383, 86805, 86806, 86807, 86808, 86812, 86813, 86816, 86817, 86821, 86825, 86826, 86828, 86829, 86830, 86831, 86832, 86833, 86834, 86835, 86849, 86950, 86985, 88240, 88241
HCPCS Codes	S2140, S2142, S2150

*Current Procedural Terminology (CPT®) ©2025 American Medical Association: Chicago, IL.

References

1. Stewart E, Federico S, Karlstrom A, et al. The Childhood Solid Tumor Network: A new resource for the developmental biology and oncology research communities. Dev Biol. Mar 15 2016; 411(2):287-293. PMID 26068307
2. Hale GA. Autologous hematopoietic stem-cell transplantation for pediatric solid tumors. Expert Rev Anticancer Ther. Oct 2005; 5(5):835-846. PMID 16221053
3. Shimada H, Ambros IM, Dehner LP, et al. Terminology and morphologic criteria of neuroblastic tumors: recommendations by the International Neuroblastoma Pathology Committee. Cancer. Jul 15 1999; 86(2):349-363. PMID 10421272
4. Tang XX, Zhao H, Kung B, et al. The MYCN enigma: significance of MYCN expression in neuroblastoma. Cancer Res. Mar 1 2006; 66(5):2826-2833. PMID 16510605
5. Attiyeh EF, London WB, Mosse YP, et al. Chromosome 1p and 11q deletions and outcome in neuroblastoma. N Engl J Med. Nov 24 2005; 353(21):2243-2253. PMID 16306521
6. Monclair T, Brodeur GM, Ambros PF, et al. The International Neuroblastoma Risk Group (INRG) staging system: an INRG Task Force report. J Clin Oncol. Jan 10 2009; 27(2):298-303. PMID 19047290
7. PDQ® Pediatric Treatment Editorial Board. PDQ Neuroblastoma Treatment. Bethesda, MD: National Cancer Institute. Updated April 28, 2025. Available at: <https://www.cancer.gov> (accessed May 15, 2026).
8. Weinstein JL, Katzenstein HM, Cohn SL. Advances in the diagnosis and treatment of neuroblastoma. Oncologist. 2003; 8(3):278-292. PMID 12773750

9. Baker DL, Schmidt ML, Cohn SL, et al. Outcome after reduced chemotherapy for intermediate-risk neuroblastoma. N Engl J Med. Sep 30 2010; 363(14):1313-1323. PMID 20879880
10. Mullassery D, Farrelly P, Losty PD. Does aggressive surgical resection improve survival in advanced stage 3 and 4 neuroblastoma? A systematic review and meta-analysis. Pediatr Hematol Oncol. Nov 2014; 31(8):703-716. PMID 25247398
11. Laprie A, Michon J, Hartmann O, et al. High-dose chemotherapy followed by locoregional irradiation improves the outcome of patients with international neuroblastoma staging system Stage II and III neuroblastoma with MYCN amplification. Cancer. Sep 01 2004; 101(5):1081-1089. PMID 15329919
12. de Alava E, Panizo A, Antonescu CR, et al. Association of EWS-FLI1 type 1 fusion with lower proliferative rate in Ewing's sarcoma. Am J Pathol. Mar 2000; 156(3):849-855. PMID 10702401
13. Khoury JD. Ewing sarcoma family of tumors. Adv Anat Pathol. Jul 2005; 12(4):212-220. PMID 16096383
14. Durer S, Shaikh H. Ewing Sarcoma. In: StatPearls. Treasure Island (FL): StatPearls Publishing; March 7, 2022.
15. Barker LM, Pendergrass TW, Sanders JE, et al. Survival after recurrence of Ewing's sarcoma family of tumors. J Clin Oncol. Jul 1 2005; 23(19):4354-4362. PMID 15781881
16. National Cancer Institute (NCI). Physician Data Query (PDQ®): Childhood rhabdomyosarcoma treatment (2025). Available at <https://www.cancer.gov> (accessed December 3, 2025).
17. Raney RB, Anderson JR, Barr FG, et al. Rhabdomyosarcoma and undifferentiated sarcoma in the first two decades of life: a selective review of intergroup rhabdomyosarcoma study group experience and rationale for Intergroup Rhabdomyosarcoma Study V. J Pediatr Hematol Oncol. May 2001; 23(4):215-220. PMID 11846299
18. Admiraal R, van der Paardt M, Kobes J, et al. High dose chemotherapy for children and young adults with stage IV rhabdomyosarcoma. Cochrane Database Syst Rev. Dec 08 2010; (12):CD006669. PMID 21154373
19. Koscielniak E, Klingebiel TH, Peters C, et al. Do patients with metastatic and recurrent rhabdomyosarcoma benefit from high-dose therapy with hematopoietic rescue? Report of the German/Austrian Pediatric Bone Marrow Transplantation Group. Bone Marrow Transplant. Feb 1997; 19(3):227-231. PMID 9028550
20. LaQuaglia MP, Gerstle JT. Advances in the treatment of pediatric solid tumors: A 50-year perspective. J Surg Oncol. Oct 2022; 126(5):933-942. PMID 36087080
21. Metzger ML, Dome JS. Current therapy for Wilms' tumor. Oncologist. 2005; 10(10):815-826. PMID 16314292
22. Campbell AD, Cohn SL, Reynolds M, et al. Treatment of relapsed Wilms' tumor with high-dose therapy and autologous hematopoietic stem-cell rescue: the experience at Children's Memorial Hospital. J Clin Oncol. Jul 15 2004; 22(14):2885-2890. PMID 15254057
23. Dallorso S, Dini G, Faraci M, et al. SCT for Wilms' tumour. Bone Marrow Transplant. Jun 2008; 41 Suppl 2:S128-S130. PMID 18545233
24. Arndt CA, Rose PS, Folpe AL, et al. Common musculoskeletal tumors of childhood and adolescence. Mayo Clin Proc. May 2012; 87(5):475-487. PMID 22560526

25. National Cancer Institute (NCI). Physician Data Query (PDQ®): Osteosarcoma and malignant fibrous histiocytoma of bone treatment (2024). Available at <https://www.cancer.gov> (accessed December 1, 2025).
26. National Cancer Institute (NCI). Physician Data Query (PDQ®): Retinoblastoma treatment: health professional version (2025). Available at <https://www.cancer.gov> (accessed November 30, 2025).
27. Dunkel IJ, Chan HS, Jubran R, et al. High-dose chemotherapy with autologous hematopoietic stem cell rescue for stage 4B retinoblastoma. Pediatr Blood Cancer. Jul 15 2010; 55(1):149-152. PMID 20486181
28. Abramson DH, Shields CL, Munier FL, et al. Treatment of retinoblastoma in 2015: agreement and disagreement. JAMA Ophthalmol. Nov 2015; 133(11):1341-1347. PMID 26378747
29. Yalçin B, Kremer LC, Caron HN, et al. High-dose chemotherapy and autologous haematopoietic stem cell rescue for children with high-risk neuroblastoma. Cochrane Database Syst Rev. Aug 22 2013; (8):CD006301. PMID 23970444
30. Matthay KK, Villablanca JG, Seeger RC, et al. Treatment of high-risk neuroblastoma with intensive chemotherapy, radiotherapy, autologous bone marrow transplantation, and 13-cis-retinoic acid. Children's Cancer Group. N Engl J Med. Oct 14 1999; 341(16):1165-1173. PMID 10519894
31. Berthold F, Boos J, Berdach S, et al. Myeloablative megatherapy with autologous stem-cell rescue versus oral maintenance chemotherapy as consolidation treatment in patients with high-risk neuroblastoma: a randomized controlled trial. Lancet Oncol. Sep 2005; 6(9):649-658. PMID 16129365
32. Pritchard J, Cotterill SJ, Germond SM, et al. High dose melphalan in the treatment of advanced neuroblastoma: results of a randomized trial (ENSG-1) by the European Neuroblastoma Study Group. Pediatr Blood Cancer. Apr 2005; 44(4):348-357. PMID 15546135
33. Yalçin B, Kremer LC, van Dalen EC. High-dose chemotherapy and autologous haematopoietic stem cell rescue for children with high-risk neuroblastoma. Cochrane Database Syst Rev. Oct 05 2015; 2015(10):CD006301. PMID 26436598
34. Żebrowska U, Balwierz W, Wechowski J, et al. Survival Benefit of Myeloablative Therapy with Autologous Stem Cell Transplantation in High-Risk Neuroblastoma: A Systematic Literature Review. Target Oncol. Mar 2024; 19(2):143-159. PMID 38401028
35. Matthay KK, Reynolds CP, Seeger RC, et al. Long-term results for children with high-risk neuroblastoma treated on a randomized trial of myeloablative therapy followed by 13-cis-retinoic acid: a Children's Oncology Group study. J Clin Oncol. Mar 1 2009; 27(7):1007-1013. PMID 19171716
36. Proust-Houdemont S, Pasqualini C, Blanchard P, et al. Busulfan-melphalan in high-risk neuroblastoma: the 30-year experience of a single institution. Bone Marrow Transplant. Aug 2016; 51(8):1076-1081. PMID 27042850
37. Giardino S, Piccardo A, Conte M, et al. 131 I-Meta-iodobenzylguanidine followed by busulfan and melphalan and autologous stem cell rescue in high-risk neuroblastoma. Pediatr Blood Cancer. Feb 2021; 68(2):e28775. PMID 33099289

38. Park JR, Kreissman SG, London WB, et al. Effect of Tandem Autologous Stem Cell Transplant vs Single Transplant on Event-Free Survival in Patients With High-Risk Neuroblastoma: A Randomized Clinical Trial. JAMA. Aug 27 2019; 322(8):746-755. PMID 31454045
39. Yan J, Jie L, Jiaxing Y, et al. Analysis of the efficacy of autologous peripheral blood stem cell transplantation in high-risk neuroblastoma. Int J Med Sci. 2022; 19(11):1715-1723. PMID 36237985
40. Sung KW, Ahn HS, Cho B, et al. Efficacy of tandem high-dose chemotherapy and autologous stem cell rescue in patients over 1 year of age with stage 4 neuroblastoma: the Korean Society of Pediatric Hematology-Oncology experience over 6 years (2000-2005). J Korean Med Sci. May 2010; 25(5):691-697. PMID 20436703
41. Ladenstein R, Pötschger U, Hartman O, et al. 28 years of high-dose therapy and SCT for neuroblastoma in Europe: lessons from more than 4000 procedures. Bone Marrow Transplant. Jun 2008; 41 Suppl 2:S118-S127. PMID 18545256
42. George RE, Li S, Mederios-Nancarrow C, et al. High-risk neuroblastoma treated with tandem autologous peripheral-blood stem-cell-supported transplantation: long-term survival update. J Clin Oncol. Jun 20 2006; 24(18):2891-2896. PMID 16782928
43. Kletzel M, Katzenstein HM, Haut PR, et al. Treatment of high-risk neuroblastoma with triple-tandem high-dose therapy and stem-cell rescue: results of the Chicago Pilot II Study. J Clin Oncol. May 1 2002; 20(9):2284-2292. PMID 11980999
44. Grupp SA, Stern JW, Bunin N, et al. Rapid-sequence tandem transplant for children with high-risk neuroblastoma. Med Pediatr Oncol. Dec 2000; 35(6):696-700. PMID 11107149
45. Pasqualini C, Dufour C, Goma G, et al. Tandem high-dose chemotherapy with thiotepa and busulfan-melphalan and autologous stem-cell transplantation in very high-risk neuroblastoma patients. Bone Marrow Transplant. Feb 2016; 51(2):227-231. PMID 26524264
46. Kim EK, Kang HJ, Park JA, et al. Retrospective analysis of peripheral blood stem-cell transplantation for the treatment of high-risk neuroblastoma. J Korean Med Sci. Sep 2007; 22(Suppl):S66-S72. PMID 17923758
47. Marcus KJ, Shamberger R, Litman H, et al. Primary tumor control in patients with stage 3/4 unfavorable neuroblastoma treated with tandem double autologous stem-cell transplants. J Pediatr Hematol Oncol. Dec 2003; 25(12):934-940. PMID 14663275
48. von Allmen D, Grupp S, Diller L, et al. Aggressive surgical therapy and radiotherapy for patients with high-risk neuroblastoma treated with rapid sequence tandem transplant. J Pediatr Surg. Jun 2005; 40(6):936-941; discussion 941. PMID 15991174
49. Ladenstein R, Pötschger U, Le Deley MC, et al. Primary disseminated multifocal Ewing sarcoma: results of the Euro-EWING 99 trial. J Clin Oncol. Jul 10 2010; 28(20):3284-3291. PMID 20547982
50. Dirksen U, Brennan B, Le Deley MC, et al. High-dose chemotherapy compared with standard chemotherapy and lung radiation in Ewing sarcoma with pulmonary metastases: results of the European Ewing Tumour Working Initiative of National Groups, 99 Trial and EWING 2008. J Clin Oncol. Dec 01 2019; 37(34):3192-3202. PMID 31553693
51. Meyers PA, Krailo MD, Ladanyi M, et al. High-dose melphalan, etoposide, total-body irradiation, and autologous stem-cell reconstitution as consolidation therapy for high-risk

Ewing's sarcoma does not improve prognosis. J Clin Oncol. Jun 1 2001; 19(11):2812-2820. PMID 11387352
52. Gardner SL, Carreras J, Boudreau C, et al. Myeloablative therapy with autologous stem-cell rescue for patients with Ewing sarcoma. Bone Marrow Transplant. May 2008; 41(10):867-872. PMID 18246113
53. Lee CY, Hou MH, Hung GY, et al. High-dose chemotherapy with autologous stem cell rescue in children and young adults with high-risk Ewing sarcoma. J Chin Med Assoc. Jan 01 2025; 88(1):85-91. PMID 39394055
54. Meyers PA. High-dose therapy with autologous stem cell rescue for pediatric sarcomas. Curr Opin Oncol. Mar 2004; 16(2):120-125. PMID 15075902
55. Loschi S, Dufour C, Oberlin O, et al. Tandem high-dose chemotherapy strategy as first-line treatment of primary disseminated multifocal Ewing sarcomas in children, adolescents and young adults. Bone Marrow Transplant. Aug 2015; 50(8):1083-1088. PMID 26030048
56. Weigel BJ, Breitfeld PP, Hawkins D, et al. Role of high-dose chemotherapy with hematopoietic stem cell rescue in the treatment of metastatic or recurrent rhabdomyosarcoma. J Pediatr Hematol Oncol. 2001; 23(5):272-276. PMID 11464981
57. McDowell HP, Foot AB, Ellershaw C, et al. Outcomes in paediatric metastatic rhabdomyosarcoma: results of the International Society of Paediatric Oncology (SIOP) study MMT-98. Eur J Cancer. Jun 2010; 46(9):1588-1595. PMID 20338746
58. Klingebiel T, Boos J, Beske F, et al. Treatment of children with metastatic soft tissue sarcoma with oral maintenance compared to high dose chemotherapy: report of the HD CWS-96 trial. Pediatr Blood Cancer. Apr 2008; 50(4):739-745. PMID 18286501
59. Carli M, Colombatti R, Oberlin O, et al. High-dose melphalan with autologous stem-cell rescue in metastatic rhabdomyosarcoma. J Clinl Oncol. Sep 1999; 17(9):2796-2803. PMID 10561355
60. Presson A, Moore TB, Kempert P. Efficacy of high-dose chemotherapy and autologous stem cell transplant for recurrent Wilms' tumor: a meta-analysis. J Pediatr Hematol Oncol. Aug 2010; 32(6):454-461. PMID 20505538
61. Garaventa A, Hartmann O, Bernard JL, et al. Autologous bone marrow transplantation for pediatric Wilms' tumor: the experience of the European bone marrow transplantation solid tumor registry. Med Pediatr Oncol. 1994; 22(1):11-14. PMID 8232074
62. Kremens B, Gruhn B, Klingebiel T, et al. High-dose chemotherapy with autologous stem rescue in children with nephroblastoma. Bone Marrow Transplant. Dec 2002; 30(12):893-898. PMID 12476282
63. Pein F, Michon J, Valteau-Couanet D, et al. High-dose melphalan, etoposide, and carboplatin followed by autologous stem-cell rescue in pediatric high-risk recurrent Wilms' tumor: a French Society of Pediatric Oncology study. J Clin Oncol. Oct 1998; 16(10):3295-3301. PMID 9779704
64. Spreafico F, Bisogno G, Collini P, et al. Treatment of high-risk relapsed Wilms' tumor with dose-intensive chemotherapy, marrow-ablative chemotherapy, and autologous hematopoietic stem cell support: Experience by the Italian association of pediatric hematology and oncology. Pediatr Blood Cancer. Feb 21 2008; 51(1):23-28. PMID 18293386
65. Kullendorff CM, Békássy AN. Salvage treatment of relapsing Wilms' tumour by autologous bone marrow transplantation. Eur J Pediatr Surg. Jun 1997; 7(3):177-179. PMID 9241510

66. Delafoy M, Verschuur A, Scheleirmacher G, et al. High-dose chemotherapy followed by autologous stem cell rescue in Wilms tumors: French report on toxicity and efficacy. Pediatr Blood Cancer. Mar 2022; 69(3):e29431. PMID 34811873
67. Malogolowkin MH, Hemmer MT, Le-Rademacher J, et al. Outcomes following autologous hematopoietic stem cell transplant for patients with relapsed Wilms' tumor: a CIBMTR retrospective analysis. Bone Marrow Transplant. Nov 2017; 52(11):1549-1555. PMID 28869618
68. Hong KT, Park HJ, Kim BK, et al. Favorable outcome of high-dose chemotherapy and autologous hematopoietic stem cell transplantation in patients with nonmetastatic osteosarcoma and low-degree necrosis. Front Oncol. 2022; 12:978949. PMID 36176408
69. Venkatramani R, Murray J, Helman L, et al. Risk-based therapy for localized osteosarcoma. Pediatr Blood Cancer. Mar 2016; 63(3):412-417. PMID 26501936
70. Hong CR, Kang HJ, Kim MS, et al. High-dose chemotherapy and autologous stem-cell transplantation with melphalan, etoposide and carboplatin for high-risk osteosarcoma. Bone Marrow Transplant. Oct 2015; 50(10):1375-1378. PMID 26098952
71. Fagioli F, Aglietta M, Tienghi A, et al. High-dose chemotherapy in the treatment of relapsed osteosarcoma: an Italian sarcoma group study. J Clin Oncol. Apr 15 2002; 20(8):2150-2156. PMID 11956277
72. Uemura S, Mori T, Ishiko S, et al. Retrospective analysis of high-dose chemotherapy followed by autologous stem cell transplantation for high-risk pediatric osteosarcoma. Pediatr Hematol Oncol. May 2020; 37(4):337-343. PMID 32151185
73. Dunkel IJ, Piao J, Chantada GL, et al. Intensive Multimodality Therapy for Extraocular Retinoblastoma: A Children's Oncology Group Trial (ARET0321). J Clin Oncol. Nov 20 2022; 40(33):3839-3847. PMID 35820112
74. Farouk Sait S, Bernot MR, Klein E, et al. Lack of complete response pretransplant is not associated with inferior overall survival for stage 4a metastatic retinoblastoma. Pediatr Blood Cancer. Jan 2023; 70(1):e29921. PMID 35934994
75. Dunkel IJ, Aledo A, Kernan NA, et al. Successful treatment of metastatic retinoblastoma. Cancer. Nov 15 2000; 89(10):2117-2121. PMID 11066053
76. Kremens B, Wieland R, Reinhard H, et al. High-dose chemotherapy with autologous stem cell rescue in children with retinoblastoma. Bone Marrow Transplant. Feb 2003; 31(4):281-284. PMID 12621463
77. Matsubara H, Makimoto A, Higa T, et al. A multidisciplinary treatment strategy that includes high-dose chemotherapy for metastatic retinoblastoma without CNS involvement. Bone Marrow Transplant. Apr 2005; 35(8):763-766. PMID 15750608
78. Rodriguez-Galindo C, Wilson MW, Haik BG, et al. Treatment of metastatic retinoblastoma. Ophthalmology. Jun 2003; 110(6):1237-1240. PMID 12799253
79. Dunkel IJ, Khakoo Y, Kernan NA, et al. Intensive multimodality therapy for patients with stage 4a metastatic retinoblastoma. Pediatr Blood Cancer. Jul 15 2010; 55(1):55-59. PMID 20486171
80. Ratko TA, Belinson SE, Brown HM, et al. Hematopoietic stem-cell transplantation in the pediatric population (Report No. 12-EHC018-EF). Rockville, MD: Agency for Healthcare Research and Quality; 2012.

81. Kanate AS, Majhail NS, Savani BN, et al. Indications for Hematopoietic Cell Transplantation and Immune Effector Cell Therapy: Guidelines from the American Society for Transplantation and Cellular Therapy. Biol Blood Marrow Transplant. Jul 2020; 26(7):1247-1256. PMID 32165328
82. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology: Bone Cancer. Version 2.2026. Available at <https://www.nccn.org> (accessed February 19, 2026).
83. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology: Soft Tissue Sarcoma. Version 2.2026. Available at <https://www.nccn.org> (accessed February 20, 2026).
84. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology: Wilms Tumor (Nephroblastoma). Version 2.2025. Available at <https://www.nccn.org> (accessed February 20, 2026).
85. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology: Neuroblastoma. Version 1.2025. Available at <https://www.nccn.org> (accessed February 20, 2026).
86. Gupta A, Dietz MS, Riedel RF, et al. Consensus recommendations for systemic therapies in the management of relapsed Ewing sarcoma: A report from the National Ewing Sarcoma Tumor Board. Cancer. Dec 01 2024; 130(23):4028-4039. PMID 39182183

Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision

Date	Description of Change
06/15/2026	Document updated. Coverage unchanged. Added references 7, 53, and 85; others updated.
01/01/2026	Document updated. The following change was made to Coverage: 1) Moved Notes 2-3 and 5 to the “Policy Guidelines” Section; 2) Removed Note 4. Added references 34 and 84; others updated/removed.
10/15/2024	Reviewed. No changes.
09/15/2023	Document updated with literature review. Coverage unchanged. The following references were added/updated: 12-14, 16, 20, 24, 37, 38, 67, 72-73, 79, and 81-83.

12/15/2022	Document updated with literature review. The following change was made to Coverage: Added “High-risk relapsed Wilms tumor” to list of indications considered medically necessary for autologous hematopoietic cell transplantation. Added/updated references: 13, 20, 21, 31, 42, 57, 58, 63, and 69-71. Document title changed from “Hematopoietic Cell Transplantation for Solid Tumors in Children”.
08/01/2021	Reviewed. No changes.
07/15/2020	Document updated with literature review. The following changes were made to Coverage: 1) On the medically necessary statement for tandem autologous HCT for high-risk neuroblastoma, removed “characterized by age older than 1 year, disseminated disease, *MYCN* oncogene amplification, and unfavorable histopathological findings”; and 2) NOTEs renumbered, with content in NOTE 1 and NOTE 5 newly added. Added or updated the following references: 7, 20, 67-68.
05/01/2019	Document updated with literature review. Coverage unchanged. References 9, 55, 67-68 added. Title changed from “Hematopoietic Stem-Cell Transplantation for Solid Tumors in Children”.
06/15/2018	Reviewed. No changes.
12/15/2017	Document updated with literature review. The following coverage statement was removed, “Allogeneic HSCT [hematopoietic stem-cell transplantation] may be considered medically necessary for initial treatment of high-risk neuroblastoma and to treat recurrent or refractory neuroblastoma.” The following wording was removed from the allogeneic HSCT experimental, investigational and/or unproven coverage statement, “except high-risk neuroblastoma and the treatment of recurrent or refractory neuroblastoma, as was noted above.” Therefore, the allogeneic HSCT experimental, investigational and/or unproven coverage statement becomes, “Allogeneic (following myeloablative or nonmyeloablative preparative regiment) HSCT is considered experimental, investigational and/or unproven for the treatment of pediatric solid tumors.” The following indication was added to the autologous HSCT medically necessary coverage statement, “metastatic retinoblastoma”. The following change was made to retinoblastoma in the autologous HSCT experimental, investigational and/or unproven coverage statement, “retinoblastoma without metastasis”.
07/01/2016	Reviewed. No changes.
09/15/2015	Document updated with literature review. Coverage unchanged. Title changed from Stem-Cell Transplant for Solid Tumors in Children.
06/01/2014	Document updated with literature review. The following was added: 1) Tandem stem-cell support may be considered medically necessary for the treatment of high-risk neuroblastoma; 2) Allogeneic stem-cell support is considered experimental, investigational and/or unproven as a salvage allogeneic transplant for relapsed Ewing’s sarcoma after prior failed autologous transplant or as an allogeneic transplant for any stage of Ewing’s

	sarcoma as an initial treatment; 3) Autologous stem-cell support may be considered medical necessary for initial treatment of high-risk Ewing's sarcoma; 4) Hematopoietic progenitor cell boost is considered experimental, investigational and/or unproven; 5) Any use of short tandem repeat (STR) markers for the treatment of neuroblastoma may be considered medically necessary; and 6) All other uses of STR markers is considered experimental, investigational and/or unproven if not listed in the coverage section.
04/01/2010	New medical document originating from: SUR703.017, Peripheral/Bone Marrow Stem-cell Transplantation (PSCT/BMT) for Non-Malignancies; SUR703.018, Peripheral/Bone Marrow Stem-cell Transplantation (PSCT/BMT) for Malignancies; SUR703.022, Cord Blood as a Source of Stem-cells (CBSC); SUR703.023, Donor Leukocyte Infusion (DLI); **and** SUR703.024, Tandem/Triple High-Dose Chemoradiotherapy with Stem-cell Support for Malignancies. Stem-cell transplant continues to be medically necessary when stated criteria are met. [NOTE: A link to the medical policies with the following titles can be found at the end of the medical policy SUR703.002, Stem-Cell Reinfusion or Transplantation Following Chemotherapy (General Donor and Recipient Information): • Peripheral/Bone Marrow Stem-cell Transplantation (PSCT/BMT) for Non-Malignancies; • Peripheral/Bone Marrow Stem-cell Transplantation (PSCT/BMT) for Malignancies; • Cord Blood as a Source of Stem-cells; • Donor Leukocyte Infusion (DLI); and Tandem/Triple High-Dose Chemoradiotherapy with Stem-cell Support for Malignancies.