

# Regence

Medical Policy Manual

Genetic Testing, Policy No. 59

## ***Genetic Testing for Myeloid Neoplasms and Leukemia***

**Effective:** January 1, 2024

**Next Review:** February 2024

**Last Review:** December 2023

### **IMPORTANT REMINDER**

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

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

### **DESCRIPTION**

Genetic testing, including testing for BCR/ABL1 (t(9;22)) translocations and for *ABL1*, *ASXL1*, *CALR*, *CEBPA*, *FLT3*, *IDH1*, *IDH2*, *JAK2*, *KIT*, *MPL*, *NPM1*, *RUNX1*, and/or *TP53* variants may inform the diagnostic, prognostic, and treatment selection processes for myelodysplastic-myeloproliferative neoplasms and select myeloid neoplasms.

### **MEDICAL POLICY CRITERIA**

**Note:** Please refer to the Cross References section below for genetic testing not addressed in this policy, including but not limited to single-gene testing.

- I. Genetic testing, including panel testing, for BCR/ABL1 translocation (Philadelphia chromosome) and/or variants in any of the following genes may be considered **medically necessary** for evaluation, diagnosis, and/or treatment monitoring in myeloid neoplasms and leukemia: *JAK2*, *CALR*, *MPL*, *ASXL1*, *IDH1*, *IDH2*, *TP53*, *CEBPA*, *FLT3*, *KIT*, *NPM1* and/or *RUNX1*.
- II. Targeted genetic panel testing for myeloproliferative neoplasms (MPN), myelodysplastic syndromes (MDS), and myelodysplastic myeloproliferative neoplasms (MPN/MDS), including acute myeloid leukemia (AML), may be considered **medically**

**necessary** for patients being evaluated for these disorders (see Policy Guidelines and Table 1).

- III. Genetic testing for *ABL1* may be considered **medically necessary** to evaluate patients when either of the following are met:
  - A. In patients with chronic myelogenous (myeloid) leukemia (CML), to monitor response to tyrosine kinase inhibitor therapy; or
  - B. In patients with Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL), to evaluate for tyrosine kinase inhibitor resistance.
- IV. Genetic testing for *ABL1* is considered **investigational** when Criterion III. is not met.
- V. Non-targeted profiling panels for hematologic disorders are considered **investigational** (see Policy Guidelines).

*NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.*

## POLICY GUIDELINES

### PANEL TESTING

#### Targeted Panels for Myeloid Neoplasms

Targeted panel testing for myeloid neoplasms, (i.e., MPN, MDS, MPN/MDS, and AML, see Table 1 below) includes panels that are specifically designed to assess variants in patients suspected of having a myeloproliferative neoplasm, a myelodysplastic syndrome, or a disorder with overlapping features. They are generally less than 50 genes and may include the following genes: *ASXL1*, *CALR*, *CBL*, *EZH2*, *KIT*, *FLT3*, *JAK2*, *MPL*, *NMP1*, *CEBPA*, *IDH1*, *IDH2*, and *TP53*.

Examples of targeted panels for MPN/MDS/AML include, but are not limited to:

- NeoTYPE™ Myeloid Disorders Profile (Neogenomics)
- NGS Myeloid 37 Gene panel (Cellnetix)
- MyeloSeq™ (Washington University School of Medicine)
- NGS\_AML Panel (Cellnetix)
- AML Mutation Analysis Panel (Molecular Pathology Laboratory Network)
- Onkosight™ Myeloid Malignancies Panel, MPN Panel, MDS Panel, or AML Panel
- Myeloid MPN/MDS/CMML Comprehensive Panel (Providence)
- Myeloid Gene Panel by NGS (University of Washington)
- TruSight® Myeloid Sequencing Panel

#### Non-targeted Panels

Some commercially available panels are not targeted toward genes that have clinical significance for a specific type of hematolymphoid disorder. They often include testing for a large number of genes that do not have demonstrated clinical utility, as well as testing for many disorders that could be distinguished based on clinical presentation.

Non-targeted panels for hematologic disorders include, but are not limited to:

- FoundationOne Heme (Foundation Medicine)
- FusionPlex Pan-Heme Panel (Laboratory for Precision Diagnostics, University of Washington)
- GeneTrails® Hematologic Malignancies 220 Gene Panel (Knight Diagnostic Laboratories)
- MyAML® 194 Targeted NGS Gene Panel (Invivoscribe)
- HopeSeq HemeComplete (City of Hope)
- NGS Hematology Molecular Profile (Sonora Quest Laboratories)
- Rapid Heme Panel (Dana-Farber Cancer Institute)
- Hematologic Malignancy Sequencing Panel (Penn Medicine)

**Table 1. World Health Organization Classification of MPN, MDS, MDS/MPN, and AML<sup>[1]</sup>**

<b>Myeloproliferative neoplasms (MPN)</b>
Chronic myeloid leukemia (CML), <i>BCR-ABL 1+</i>
Chronic neutrophilic leukemia (CNL)
Polycythemia vera (PV)
Primary myelofibrosis (PMF)
PMF, prefibrotic/early stage
PMF, overt fibrotic stage
Essential thrombocythemia (ET)
Chronic eosinophilic leukemia, not otherwise specified (NOS)
MPN, unclassifiable
Mastocytosis
<b>Myelodysplastic/myeloproliferative neoplasms (MDS/MPN)</b>
Chronic myelomonocytic leukemia (CMML)
Atypical chronic myeloid leukemia (aCML), <i>BCR-ABL 1-</i>
Juvenile myelomonocytic leukemia (JMML)
MDS/MPN with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T)
MDS/MPN, unclassifiable
<b>Myelodysplastic syndromes (MDS)</b>
MDS with single lineage dysplasia
MDS with ring sideroblasts (MDS-RS)
MDS-RS and single lineage dysplasia
MDS-RS and multilineage dysplasia
MDS with multilineage dysplasia
MDS with excess blasts
MDS with isolated del(5q)
MDS, unclassifiable
<i>Provisional entity: Refractory cytopenia of childhood</i>
Myeloid neoplasms with germ line predisposition
<b>Acute myeloid leukemia (AML) and related neoplasms</b>
AML with recurrent genetic abnormalities
AML with t(8;21)(q22;q22.1); <i>RUNX1-RUNX1T1</i>
AML with inv(16)(p13.1q22) or t(16;16)(p13.1;q22); <i>CBFB-MYH11</i>
APL with <i>PML-RARA</i>
AML with t(9;11)(p21.3;q23.3); <i>MLLT3-KMT2A</i>
AML with t(6;9)(p23;q34.1); <i>DEK-NUP214</i>
AML with inv(3)(q21.3q26.2) or t(3;3)(q21.3;q26.2); <i>GATA2, MECOM</i>
AML (megakaryoblastic) with t(1;22)(p13.3;q13.3); <i>RBM15-MKL1</i>
<i>Provisional entity: AML with BCR-ABL 1</i>
AML with mutated <i>NPM1</i>
AML with biallelic mutations of <i>CEBPA</i>

*Provisional entity: AML with mutated RUNX1*  
AML with myelodysplasia-related changes  
Therapy-related myeloid neoplasms  
AML, NOS  
AML with minimal differentiation  
AML without maturation  
AML with maturation  
Acute myelomonocytic leukemia  
Acute monoblastic/monocytic leukemia  
Pure erythroid leukemia  
Acute megakaryoblastic leukemia  
Acute basophilic leukemia  
Acute panmyelosis with myelofibrosis  
Myeloid sarcoma  
Myeloid proliferations related to Down syndrome  
Transient abnormal myelopoiesis (TAM)  
Myeloid leukemia associated with Down syndrome

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## LIST OF INFORMATION NEEDED FOR REVIEW

### REQUIRED DOCUMENTATION:

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome:

1. Name of the genetic test(s) or panel test
2. Name of the performing laboratory and/or genetic testing organization (more than one may be listed)
3. The exact gene(s) and/or variant(s) being tested
4. Relevant billing codes
5. Brief description of how the genetic test results will guide clinical decisions that would not otherwise be made in the absence testing
6. Medical records related to this genetic test:
  - o History and physical exam including any relevant diagnoses related to the genetic testing
  - o Sample collection (e.g., blood draw) date
  - o Conventional testing and results

## CROSS REFERENCES

1. [Genetic Testing for Hereditary Breast and Ovarian Cancer and Li-Fraumeni Syndrome](#), Genetic Testing, Policy No. 02
2. [Genetic Testing for  \$\alpha\$ -Thalassemia](#), Genetic Testing, Policy No. 19
3. [Genetic and Molecular Diagnostic Testing](#), Genetic Testing, Policy No. 20
4. [Hematopoietic Cell Transplantation for Acute Myeloid Leukemia](#), Transplant, Policy No. 45.28
5. [Hematopoietic Cell Transplantation for Chronic Myelogenous Leukemia](#), Transplant, Policy No. 45.31
6. [Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia](#), Transplant, Policy No. 45.36
7. [Medication Policy Manual](#), Do a find (Ctrl+F) and enter drug name in the find bar to locate the appropriate policy.

## BACKGROUND

### DIAGNOSING MYELOID NEOPLASMS AND ACUTE LEUKEMIA

Myeloid neoplasms may be acute or chronic, are a type of hematologic malignancy, and usually derive from bone marrow progenitor cells that normally develop into erythrocytes, granulocytes (neutrophils, basophils, and eosinophils), monocytes, or megakaryocytes. Classification of myeloid neoplasms and acute leukemias has evolved over the past decade, based in part on the advancement of available technologies and results from repeat validation studies.

In recent history, diagnosis of the various forms of myeloid neoplasms has been based on a complex set of clinical, pathological, and biological criteria first introduced by the Polycythemia Vera Study Group (PVSG) in 1996<sup>[2, 3]</sup> and the World Health Organization (WHO) in 2001.<sup>[4]</sup> Both of these classifications use a combination of clinical, pathological, and/or biological criteria to arrive at a definitive diagnosis, predominantly reliant on status of Philadelphia chromosome presence. An important component of the diagnostic process is a clinical and laboratory assessment to rule out reactive or secondary causes of disease. Some diagnostic methods (e.g., bone marrow microscopy) are not well standardized and others (e.g., endogenous erythroid colony formation) are neither standardized nor widely available.<sup>[5-7]</sup> Diagnosis and monitoring of patients with Philadelphia chromosome negative myeloid neoplasms poses a challenge because many of the laboratory and clinical features of these diseases can be mimicked by other conditions such as reactive or secondary erythrocytosis, thrombocytosis or myeloid fibrosis. In addition, these entities can be difficult to distinguish on morphological bone marrow exam and diagnosis can be complicated by changing disease patterns.

The most up-to-date classification and benchmark for diagnosis of hematopoietic and lymphoid tissues is a result of collaboration between the Society for Hematopathology and the European Association for Haematopathology and is published by the WHO, most recently in 2016.<sup>[1, 8]</sup> This edition varies from the previous versions predominantly due to advances in available technologies to identify unique biomarkers associated with myeloid neoplasms and acute leukemias. The current classification of myeloid neoplasm and acute leukemia subgroups are delineated in Table 2.

**Table 2. WHO Myeloid Neoplasm and Acute Leukemia Classification<sup>[1]</sup>**

WHO myeloid neoplasm and acute leukemia classification	WHO myeloid neoplasm and acute leukemia classification
<b>Myeloproliferative neoplasms (MPN)</b>	Myeloid/lymphoid neoplasms with <i>FGFR1</i> rearrangement <i>Provisional entity: Myeloid/lymphoid neoplasms with <i>PCM1-JAK2</i></i>
Chronic myeloid leukemia (CML), <i>BCR-ABL1</i> <sup>+</sup>	
Chronic neutrophilic leukemia (CNL)	
Polycythemia vera (PV)	
Primary myelofibrosis (PMF)	<b>Myelodysplastic/myeloproliferative neoplasms (MDS/MPN)</b>
PMF, prefibrotic/early stage	Chronic myelomonocytic leukemia (CMML)
PMF, overt fibrotic stage	Atypical chronic myeloid leukemia (aCML), <i>BCR-ABL1</i> <sup>-</sup>
Essential thrombocythemia (ET)	Juvenile myelomonocytic leukemia (JMML)
Chronic eosinophilic leukemia, not otherwise specified (NOS)	MDS/MPN with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T)
MPN, unclassifiable	MDS/MPN, unclassifiable
Mastocytosis	<b>Myelodysplastic syndromes (MDS)</b>
<b>Myeloid/lymphoid neoplasms with eosinophilia and rearrangement of <i>PDGFRA</i>, <i>PDGFRB</i>, or <i>FGFR1</i>, or with <i>PCM1-JAK2</i></b>	MDS with single lineage dysplasia
Myeloid/lymphoid neoplasms with <i>PDGFRA</i> rearrangement	MDS with ring sideroblasts (MDS-RS)
Myeloid/lymphoid neoplasms with <i>PDGFRB</i> rearrangement	MDS-RS and single lineage dysplasia
	MDS-RS and multilineage dysplasia
	MDS with multilineage dysplasia

## WHO myeloid neoplasm and acute leukemia classification

MDS with excess blasts  
MDS with isolated del(5q)  
MDS, unclassifiable  
*Provisional entity: Refractory cytopenia of childhood*  
Myeloid neoplasms with germ line predisposition  
**Acute myeloid leukemia (AML) and related neoplasms**  
AML with recurrent genetic abnormalities  
AML with t(8;21)(q22;q22.1); *RUNX1-RUNX1T1*  
AML with inv(16)(p13.1q22) or t(16;16)(p13.1;q22); *CBFB-MYH11*  
APL with *PML-RARA*  
AML with t(9;11)(p21.3;q23.3); *MLLT3-KMT2A*  
AML with t(6;9)(p23;q34.1); *DEK-NUP214*  
AML with inv(3)(q21.3q26.2) or t(3;3)(q21.3;q26.2); *GATA2, MECOM*  
AML (megakaryoblastic) with t(1;22)(p13.3;q13.3); *RBM15-MKL1*  
*Provisional entity: AML with BCR-ABL1*  
AML with mutated *NPM1*  
AML with biallelic mutations of *CEBPA*  
*Provisional entity: AML with mutated RUNX1*  
AML with myelodysplasia-related changes  
Therapy-related myeloid neoplasms  
AML, NOS  
AML with minimal differentiation  
AML without maturation  
AML with maturation  
Acute myelomonocytic leukemia  
Acute monoblastic/monocytic leukemia  
Pure erythroid leukemia  
Acute megakaryoblastic leukemia  
Acute basophilic leukemia  
Acute panmyelosis with myelofibrosis  
Myeloid sarcoma

## WHO myeloid neoplasm and acute leukemia classification

Myeloid proliferations related to Down syndrome  
Transient abnormal myelopoiesis (TAM)  
Myeloid leukemia associated with Down syndrome  
**Blastic plasmacytoid dendritic cell neoplasm**  
**Acute leukemias of ambiguous lineage**  
Acute undifferentiated leukemia  
Mixed phenotype acute leukemia (MPAL) with t(9;22)(q34.1;q11.2); *BCR-ABL1*  
MPAL with t(v;11q23.3); *KMT2A* rearranged  
MPAL, B/myeloid, NOS  
MPAL, T/myeloid, NOS  
**B-lymphoblastic leukemia/lymphoma**  
B-lymphoblastic leukemia/lymphoma, NOS  
B-lymphoblastic leukemia/lymphoma with recurrent genetic abnormalities  
B-lymphoblastic leukemia/lymphoma with t(9;22)(q34.1;q11.2); *BCR-ABL1*  
B-lymphoblastic leukemia/lymphoma with t(v;11q23.3); *KMT2A* rearranged  
B-lymphoblastic leukemia/lymphoma with t(12;21)(p13.2;q22.1); *ETV6-RUNX1*  
B-lymphoblastic leukemia/lymphoma with hyperdiploidy  
B-lymphoblastic leukemia/lymphoma with hypodiploidy  
B-lymphoblastic leukemia/lymphoma with t(5;14)(q31.1;q32.3) *IL3-IGH*  
B-lymphoblastic leukemia/lymphoma with t(1;19)(q23;p13.3); *TCF3-PBX1*  
*Provisional entity: B-lymphoblastic leukemia/lymphoma, BCR-ABL1-like*  
*Provisional entity: B-lymphoblastic leukemia/lymphoma with iAMP21*  
**T-lymphoblastic leukemia/lymphoma**  
*Provisional entity: Early T-cell precursor lymphoblastic leukemia*  
*Provisional entity: Natural killer (NK) cell lymphoblastic leukemia/lymphoma*

It is important to note that the presence of any one or more of the gene variants included in this policy may not be sufficient to confirm a diagnosis, rather, testing may help support other clinical, laboratory, or pathological findings.

## TREATMENT MONITORING

CML represents one of the earliest examples of the use of molecular information to revolutionize patient management. A unique chromosomal change (the Philadelphia chromosome) and an accompanying unique gene rearrangement (*BCR-ABL*) resulting in a continuously activated tyrosine kinase enzyme were identified. These led to the development of a targeted tyrosine kinase inhibitor drug therapy (imatinib) that produces long-lasting remissions.

## REGULATORY STATUS

More than a dozen commercial laboratories currently offer a wide variety of diagnostic procedures for gene variant testing related to myeloid neoplasms and acute lymphoblastic leukemia. These tests are available as laboratory developed procedures under the U.S. Food and Drug Administration (FDA) enforcement discretion policy for laboratory developed tests (LDTs). Clinical laboratories may develop and validate tests in-house and market them as a laboratory service; LDTs must meet the general regulatory standards of Clinical Laboratory Improvement Act (CLIA) and laboratories that offer LDTs must be licensed by CLIA for high-complexity testing. To date, FDA does not require regulatory review of LDTs.

The FDA Centers for Devices and Radiological Health (CDRH), for Biologics Evaluation and Research (CBER), and for Drug Evaluation and Research (CDER) developed a draft guidance on in vitro companion diagnostic devices, which was released on July 14, 2011,<sup>[9]</sup> to address the “emergence of new technologies that can distinguish subsets of populations that respond differently to treatment.” As stated, the FDA encourages the development of treatments that depend on the use of companion diagnostic devices “when an appropriate scientific rationale supports such an approach.” In such cases, the FDA intends to review the safety and effectiveness of the companion diagnostic test as used with the therapeutic treatment that depends on its use. The rationale for co-review and approval is the desire to avoid exposing patients to preventable treatment risk.

The LeukoStrat<sup>®</sup> CDx *FLT3* Mutation Assay offered by Invivoscribe. According to Invivoscribe, the test is indicated at initial diagnosis of AML to determine eligibility for Rydapt<sup>®</sup> (midostaurin), and may also be used for risk stratification.<sup>[10]</sup> The assay includes internal tandem duplication variant testing for *FLT3* as well as variants in the tyrosine kinase domain. Rydapt<sup>®</sup> (midostaurin) is an FDA-approved kinase inhibitor, indicated for adult patients, in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation.<sup>[11]</sup> The assay is an FDA-approved companion diagnostic test for use with Rydapt<sup>®</sup> (midostaurin) and therefore may be standard of care in screening patients for use with this specific kinase inhibitor.

Abbott RealTime IDH2 is an *in vitro* polymerase chain reaction (PCR) assay for the qualitative detection of single nucleotide variants (SNVs) in the human isocitrate dehydrogenase-2 (IDH2) gene. The test aids in identifying acute myeloid leukemia patients for treatment with Idhifa<sup>®</sup> (enasidenib). Enasidenib is an oral medication used to treat patients with AML when the disease recurs after or does not respond to front-line therapies. The Abbott RealTime IDH2 assay received FDA premarket approval in August 2017.

## EVIDENCE SUMMARY

Human Genome Variation Society (HGVS) nomenclature is used to describe variants found in DNA and serves as an international standard.<sup>[12]</sup> It is being implemented for genetic testing medical evidence review updates starting in 2017. According to this nomenclature, the term “variant” is used to describe a change in a DNA or protein sequence, replacing previously-used terms, such as “mutation.” Pathogenic variants are variants associated with disease, while benign variants are not. The majority of genetic changes have unknown effects on human health, and these are referred to as variants of uncertain significance.

Validation of the clinical use of any genetic test focuses on three main principles:

1. The analytic validity of the test, which refers to the technical accuracy of the test in detecting a variant that is present or in excluding a variant that is absent;

2. The clinical validity of the test, which refers to the diagnostic performance of the test (sensitivity, specificity, positive and negative predictive values) in detecting clinical disease; and
3. The clinical utility of the test, i.e., how the results of the diagnostic test will be used to change management of the patient and whether these changes in management lead to clinically important improvements in health outcomes.

The focus of this review is on evidence related to the ability of test results to:

- Guide decisions in the clinical setting related to either treatment, management, or prevention, and
- Improve health outcomes as a result of those decisions.

## **BCR-ABL1 (ABL1) KINASE DOMAIN ANALYSIS**

Screening for *BCR-ABL1* kinase domain variants in chronic phase CML is recommended for patients with inadequate initial response to TKI treatment, those with evidence of loss of response, and for patients who have progressed to accelerated or blast phase CML.<sup>[2]</sup> The focus of the following discussion is on kinase domain point variants and treatment outcomes in systematic reviews.

In 2010, the Agency for Healthcare Research and Quality published a systematic review on *BCR-ABL1* pharmacogenetic testing for tyrosine kinase inhibitors in CML.<sup>[13]</sup> Thirty-one publications of *BCR-ABL1* testing met the eligibility criteria and were included in the review (20 of dasatinib, seven of imatinib, three of nilotinib, and one with various TKIs). The report concluded that the presence of any *BCR-ABL1* variant does not predict differential response to TKI therapy, although the presence of the T315I variant uniformly predicts TKI failure. However, during the public comment period the review was strongly criticized by respected pathology organizations for lack of attention to several issues that were subsequently insufficiently addressed in the final report. Importantly, the review grouped together studies that used kinase domain variant screening methods with those that used targeted methods and combined studies that used variant detection technologies with very different sensitivities. The authors dismissed the issues as related to analytic validity and beyond the scope of the report. However, in this clinical scenario assays with different intent (screening vs. targeted) and assays of very different sensitivities may lead to different clinical conclusions, so an understanding of these points is critical.

Branford (2009) summarized much of the available evidence regarding kinase domain variants detected at imatinib failure, and subsequent treatment success or failure with dasatinib or nilotinib.<sup>[14]</sup> The T315I variant was most common; although about 100 variants have been reported, the seven most common (at residues T315, Y253, E255, M351, G250, F359, and H396) accounted for 60-66% of all variants. However, preexisting or emerging variants T315A, F317L/I/V/C, and V299L are associated with decreased clinical efficacy with dasatinib treatment following imatinib failure. Detection of the T315I variant at imatinib failure is associated with lack of subsequent response to high-dose imatinib, or to dasatinib or nilotinib. For these patients, allogeneic stem-cell transplantation remained the only available treatment until the advent of new agents such as ponatinib.<sup>[15]</sup> However these variants do not correspond to clinical significance, and based on clinical studies, the majority of imatinib-resistant variants remain sensitive to dasatinib and nilotinib.



Preexisting or emerging variants T315A, F317L/I/V/C, and V299L are associated with decreased clinical efficacy with dasatinib treatment following imatinib failure. Similarly, preexisting or emerging variants Y253H, E255K/V, and F359V/C have been reported for decreased clinical efficacy with nilotinib treatment following imatinib failure. In the survey reported by Branford, a total of 42% of patients tested had T315I or one of these dasatinib- or nilotinib-resistant variants. In the absence of any of these actionable variants, various treatment options are available. Note that these data have been obtained from studies in which patients were all initially treated with imatinib; no data are available regarding variants developing during first-line therapy with dasatinib or nilotinib.<sup>[16]</sup>

Unlike in CML, resistance in ALL to TKIs is less well studied. Resistance does not necessarily arise from dominant tumor clone(s), but possibly in response to TKI-driven selective pressure and/or by competition of other coexisting subclones.<sup>[17]</sup> In patients with ALL that are receiving a TKI, a rise in the BCR-ABL level while in hematologic complete response or clinical relapse warrants variant analysis.

### **ASXL1, CALR, IDH1, IDH2 AND TP53 IN MYELOID NEOPLASMS AND LEUKEMIA**

Testing for the *ASXL1*, *CALR*, *IDH1*, *IDH2* and *TP53* is required to meet WHO diagnostic criteria for patients with all of the most common Philadelphia chromosome-negative MPNs. It is important to note that the 2008 WHO revision represents expert consensus and is not based on independent validation of the 2008 criteria compared to earlier diagnostic criteria or on clinical outcomes. However, the most recent revisions to the WHO criteria (2016) are heavily based on repeat validation studies.<sup>[1]</sup> The following evidence highlights the diagnostic and prognostic significance of *ASXL1*, *CALR*, *IDH1*, *IDH2* and *TP53* as specified by WHO diagnostic criteria and National Comprehensive Cancer Network (NCCN) guidelines.

#### **ASXL1**

For chronic myelomonocytic leukemia (CMML), *ASXL1* is amongst the most frequently mutated genes, observed in 40-50% of CMML patients.<sup>[18, 19]</sup> *ASXL1* is also reported to be associated with chromatin modification in MPNs, including polycythemia vera, as well as pre- and overt primary myelofibrosis.<sup>[20, 21]</sup>

#### **CALR**

Evidence for *CALR* demonstrates that a significant proportion of patients with myeloproliferative neoplasms and normal *JAK2* V617F status have a *CALR* variant.<sup>[22-24]</sup> Variants in exon 9 of *CALR* are found in 20-35% of all patients with ET and myelofibrosis. Fifty-two base pair deletions (*Type 1*) and five base pair insertions (*Type 2*) are the most common.

It is suggested that ET patients with *CALR* variants have lower polycythemic transformation rates, but not lower myelofibrotic transformation rate, compared with ET patients harboring a *JAK2* variant. Chen (2014) reported a higher platelet count, younger age of diagnosis, lower leukocyte count, and decreased risk for thrombosis, compared with a *JAK2* positive ET population.<sup>[25]</sup> Tefferi (2014) reported survival and blast transformation in primary myelofibrosis (PMF) were significantly affected by variant status, though not in ET.<sup>[26]</sup> The outcome was best in *CALR*-variant patients and worst in *JAK2/CALR/MPL*-negative PMF patients. *CALR*-variant ET has also been associated with better thrombosis-free survival and lower leukocyte counts. However, overall survival has been reported as not different among *CALR*-variant and non-variant ET.<sup>[27, 28]</sup>

## **IDH1/2**

For PMF and ET, WHO criteria specify *IDH1/2* (as well as others, including *ASXL1*) as having diagnostic significance for those without *JAK2*, *CALR*, and *MPL* variants. In myeloproliferative neoplasms, *IDH1* and *IDH2* variants are among a growing number of higher-risk molecular markers. Both are associated with shorter overall survival and leukemia-free survival in patients with PMF and polycythemia vera.<sup>[21, 29]</sup> In a study of the prognostic significance of *ASXL1*, *EZH2*, *SRSF2*, *IDH1* and *IDH2*, Vannucchi (2013) analyzed samples from 897 PMF patients (483 European patients and 396 from the Mayo clinical validation cohort). Median survival was significantly shorter (81 vs. 148 months,  $p < 0.0001$ ) in PMF patients with at least one of the genes.

## **TP53**

Like *IDH1/2* described above, for PMF, *TP53* is associated with leukemic transformation, which is a common risk amongst patients with myeloproliferative neoplasms.<sup>[30]</sup> Furthermore, *TP53* is associated with inferior leukemia-free survival in those with ET. This progression is associated with poor clinical outcomes and resistance to standard AML therapies. Thus, *TP53* variants have also been analyzed to subdivide AML into prognostic subsets (see below). Additionally, *TP53* variants have been identified as one of the most common molecular abnormalities associated with myelodysplastic syndromes and may aid in diagnosis.<sup>[31-33]</sup>

## **ACUTE MYELOID LEUKEMIA**

AML is a group of diverse hematologic malignancies characterized by the clonal expansion of myeloid blasts in the bone marrow, blood, and/or other tissues. It is the most common type of leukemia in adults and is generally associated with a poor prognosis. It was estimated that in 2014, 18,860 people would be diagnosed with AML and 10,460 would die of the disease. Median age at diagnosis is 66 years, with approximately one in three patients diagnosed at 75 years of age or older.<sup>[34]</sup>

Conventional cytogenetic analysis (karyotyping) is a key component of the diagnostic evaluation of patients with suspected acute leukemia. The cytogenetic profile of the tumor is currently the most powerful predictor of prognosis in AML and is used to guide risk-adapted treatment strategies. Molecular variants, including those in *CEBPA*, *FLT3*, *KIT*, *NPM1*, *RUNX1*, and *TP53* genes, can be used to subdivide AML into prognostic subsets. (See Table 3.) Patients with better-prognosis disease based on cytogenetics (e.g., core-binding factor AML) who have a *c-KIT* variant in leukemic blast cells do just as poorly with post-remission standard chemotherapy as patients with cytogenetically poor-risk AML.<sup>[35]</sup> Similarly, individuals with cytogenetically normal AML (intermediate-prognosis disease) can be subcategorized into groups with better or worse prognosis based on the variant status of the *NPM1* and *FLT3* genes. Patients with variants in *NPM1* but without a *FLT3-ITD* fusion have post-remission outcomes with standard chemotherapy that are similar to those with better-prognosis cytogenetics; in contrast, patients with any other combination of variants in those genes have outcomes similar to those with poor-prognosis cytogenetics.<sup>[36]</sup> A provisional category of AML with a *RUNX1* variant classifies de novo cases which are not associated with MDS-related cytogenetic abnormalities. This distinct group of AML patients also appears to have a worse prognosis than other AML types.<sup>[37-40]</sup>

The World Health Organization (WHO) classification of AML was adapted by the NCCN to estimate individual patient prognosis to guide management, as shown in Table 3.<sup>[41]</sup>

**Table 3. Risk Status of AML Based on Cytogenetic and Molecular Factors**

Risk Category	Genetic Abnormality
Favorable	t(8;21)(q22;q22.1); <i>RUNX1-RUNX1T1</i> inv(16)(p13.1q22) or t(16;16)(p13.1;q22); <i>CBFB-MYH11</i> Biallelic mutated <i>CEBPA</i> Mutated <i>NPM1</i> without <i>FLT3-ITD</i> or with <i>FLT3-ITD</i> <sup>low</sup>
Intermediate	Mutated <i>NPM1</i> and <i>FLT3-ITD</i> <sup>high</sup> Wild-type <i>NPM1</i> without <i>FLT3-ITD</i> or with <i>FLT3-ITD</i> <sup>low</sup> (without adverse risk genetic lesions) t(9;11)(p21.3;q23.3); <i>MLLT3-KMT2A</i> Cytogenetic abnormalities not classified as favorable or adverse
Poor/Adverse	t(6;9)(p23;q34.1); <i>DEK-NUP214</i> t(v;11q23.3); <i>KMT2A</i> rearranged t(9;22)(q34.1;q11.2); <i>BCR-ABL1</i> inv(3)(q21.3;q26.2) or t(3;3)(q21.3;q26.2); <i>GATA2</i> , <i>MECOM(EV11)</i> -5 or del(5q); -7; -17/abn(17p) Complex karyotype, monosomal karyotype Wild-type <i>NPM1</i> and <i>FLT3-ITD</i> <sup>high</sup> Mutated <i>RUNX1</i> Mutated <i>ASXL1</i> Mutated <i>TP53</i>

### Genetic Testing for Molecular Subtypes of AML

A number of systematic reviews with meta-analyses have highlighted the evolving classification of AML into distinct molecular subtypes based on *CEBPA*, *FLT3-ITD*, *KIT*, *NPM1*, and *TP53*, particularly in patients with normal karyotype.<sup>[42-47]</sup> These studies support the WHO and NCCN risk status classifications, and additionally highlight the importance of *KIT* testing in the initial evaluation and for prognosis.

### PANEL TESTING FOR MYELOID NEOPLASMS

As indicated in NCCN guidelines and the WHO classification system, testing for variants in multiple genes may be indicated for diagnosis or treatment decisions in patients diagnosed with, or suspected of having, a myeloid neoplasm (see Practice Guideline Summary below). A number of studies have been published that describe the use of genetic panel tests that include these genes for diagnosis and prognosis of AML<sup>[48-52]</sup> and MDS<sup>[53-55]</sup>

## PRACTICE GUIDELINE SUMMARY

### WORLD HEALTH ORGANIZATION

In 2016 the WHO published diagnostic criteria for myeloid neoplasms and acute leukemia, which include testing for a number of genetic variants, as shown in Table 2.<sup>[1]</sup>

### NATIONAL COMPREHENSIVE CANCER NETWORK

The NCCN has published guidelines for Chronic Myeloid Leukemia (v.1.2023)<sup>[56]</sup>, Acute Lymphoblastic Leukemia (v.1.2022)<sup>[57]</sup>, which include recommendations regarding *BCR-ABL1* testing.

NCCN guidelines for Acute Myeloid Leukemia (v.3.2023)<sup>[41]</sup>, Myelodysplastic Syndromes (v.1.2023)<sup>[58]</sup>, and Myeloproliferative Neoplasms (v.3.2022)<sup>[59]</sup> include recommendations for

testing a number of genes that have clinical significance for these disorders, including *JAK2*, *CALR*, *MPL*, *ASXL1*, *IDH1*, *IDH2*, *TP53*, *CEBPA*, *FLT3*, *KIT*, *NPM1*, and *RUNX1*.

## SUMMARY

### **BCR/ABL1 (t(9;22)) TRANSLOCATION ANALYSIS, *JAK2*, *CALR*, *MPL*, *ASXL1*, *IDH1*, *IDH2*, *TP53*, *CEBPA*, *FLT3*, *KIT*, *NPM1* AND/OR *RUNX1***

There is enough research to show that *BCR/ABL1* (t(9;22)) translocation analysis (Philadelphia chromosome) and genetic testing for *JAK2*, *CALR*, *MPL*, *ASXL1*, *IDH1*, *IDH2*, *TP53*, *CEBPA*, *FLT3*, *KIT*, *NPM1* and/or *RUNX1* variants is important to guide diagnosis and treatment of myeloid neoplasms and leukemia. Additionally, these tests are recommended by clinical practice guidelines for various myeloid disorders. Therefore, testing for *BCR/ABL1* (t(9;22)) translocation analysis (Philadelphia chromosome) and genetic testing for *JAK2*, *CALR*, *MPL*, *ASXL1*, *IDH1*, *IDH2*, *TP53*, *CEBPA*, *FLT3*, *KIT*, *NPM1* and/or *RUNX1* variants is considered medically necessary for evaluation, diagnosis, and/or treatment monitoring for myeloid neoplasms and leukemia.

### **BCR-ABL KINASE DOMAIN (*ABL1*)**

In chronic myeloid leukemia, there is enough research to show clinical utility for evaluation of *ABL1* variants for tyrosine kinase inhibitor (TKI) resistance. TKI resistance in acute lymphoblastic leukemia (ALL) has not been studied as well as in CML. However, there is enough research to show *ABL1* genetic testing for evaluation of TKI resistance may lead to an improvement in health outcomes for patients with ALL who are receiving a TKI. Practice guidelines based on research recommend *ABL1* testing for ALL and CML in specific clinical scenarios. Therefore, *ABL1* genetic testing for evaluation of TKI resistance may be considered medically necessary when policy criteria are met. Due to insufficient evidence, evaluation of *ABL1* variants is considered investigational when policy criteria are not met.

### **TARGETED PANEL TESTING**

There is enough research to show that targeted panel testing may be important for diagnosis and guide treatment decisions for patients suspected of having or diagnosed with myeloproliferative neoplasms (MPN), myelodysplastic syndromes (MDS), and myelodysplastic myeloproliferative neoplasms (MPN/MDS), including acute myeloid leukemia (AML). Clinical practice guidelines recommend panel testing for these disorders. Therefore, targeted panel testing for MPN, MDS, MPN/MDS or AML may be considered medically necessary.

### **NON-TARGETED PANEL TESTING**

Non-targeted panels include testing for a large number of genes and are not targeted toward genes that have clinical significance for a specific type of hematolymphoid disorder. They often include testing for many genes that are not necessary to guide treatment, as well as testing for disorders that could be distinguished based on clinical presentation. There are no clinical practice guidelines based on research that recommend testing for all of the genes in these panels. Therefore, the use of non-targeted hematologic panel testing is considered investigational.

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## CODES

**NOTE:** BCR/ABL1 (t(9;22)) translocation analysis has specific CPT codes: 81206-8, 0016U, and 0040U. This differs from than BCR-ABL kinase domain (*ABL1*) variant analysis.

Codes	Number	Description
CPT	0016U	Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation



Codes	Number	Description
	0017U	Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected
	0023U	Oncology (acute myelogenous leukemia), DNA, genotyping of internal tandem duplication, p.D835, p.I836, using mononuclear cells, reported as detection or non-detection of FLT3 mutation and indication for or against the use of midostaurin
	0027U	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15
	0040U	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis, major breakpoint, quantitative
	0046U	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia) internal tandem duplication (ITD) variants, quantitative
	0049U	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, quantitative
	0050U	Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements
	81120	IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble) (eg, glioma), common variants (eg, R132H, R132C)
	81121	IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (eg, glioma), common variants (eg, R140W, R172M)
	81170	ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib tyrosine kinase inhibitor resistance), gene analysis, variants in the kinase domain
	81175	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; full gene sequence
	81176	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; targeted sequence analysis (eg, EXON 12)
	81206	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative
	81207	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative
	81208	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative
	81218	CEBPA (CCAAT/enhancer binding protein [C/EBP], alpha) (eg, acute myeloid leukemia), gene analysis, full gene sequence
	81219	CALR (calreticulin) (eg, myeloproliferative disorders), gene analysis, common variants in exon 9
	81245	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; internal tandem duplication (ITD) variants (ie, exons 14, 15)
	81246	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; tyrosine kinase domain (TKD) variants (eg, D835, I836)
	81270	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant
	81272	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, gastrointestinal stromal tumor [GIST], acute myeloid leukemia, melanoma), gene analysis, targeted sequence analysis (eg, exons 8, 11, 13, 17, 18)

Codes	Number	Description
	81273	<i>KIT</i> (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, mastocytosis), gene analysis, D816 variant(s)
	81279	<i>JAK2</i> (Janus kinase 2) (eg, myeloproliferative disorder) targeted sequence analysis (eg, exons 12 and 13)
	81310	<i>NPM1</i> (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, exon 12 variants
	81334	<i>RUNX1</i> (runt related transcription factor 1) (eg, acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy), gene analysis, targeted sequence analysis (eg, EXONS 3-8)
	81338	<i>MPL</i> ( <i>MPL</i> proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; common variants (eg, W515A, W515K, W515L, W515R)
	81339	<i>MPL</i> ( <i>MPL</i> proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; sequence analysis, exon 10
	81351	<i>TP53</i> (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; full gene sequence
	81352	<i>TP53</i> (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; targeted sequence analysis (eg, 4 oncology)
	81353	<i>TP53</i> (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; known familial variant
	81401	Molecular pathology procedure, Level 2 - which includes <i>ABL1</i> ( <i>ABL proto oncogene 1, non-receptor tyrosine kinase</i> ) (eg, acquired imatinib resistance), T315I variant
	81402	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)
	81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)
	81450	Hematolymphoid neoplasm or disorder, genomic sequence analysis panel, 5-50 genes, interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis
	81451	Hematolymphoid neoplasm or disorder, genomic sequence analysis panel, 5-50 genes, interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; RNA analysis
	81455	Solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes, genomic sequence analysis panel, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed DNA analysis or combined DNA and RNA analysis
	81456	Solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes, genomic sequence analysis panel, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; RNA analysis
HCPCS	None	

**Date of Origin:** August 2010