

<b>Subject:</b> Plasmapheresis for Renal and Non-renal Indications		<b>Original Effective Date:</b> 4/24/2013
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**DISCLAIMER**

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**DESCRIPTION OF PROCEDURE/SERVICE/PHARMACEUTICAL**

Plasmapheresis or therapeutic plasma exchange is a blood purification procedure primarily used to treat autoimmune diseases and other disease states that is conducted in outpatient settings, including blood banks, dialysis centers, hospitals, and physicians' offices. The procedure involves removing whole blood from the patient and separating the blood into plasma and blood cells. The plasma is removed and replaced with another solution, such as saline solution, albumin, or specially prepared donor plasma; and the reconstituted solution is then returned to the patient. The procedure is most commonly used to treat a variety of disorders such as Goodpasture's syndrome, myasthenia gravis, Guillain-Barré syndrome, lupus, and thrombotic thrombocytopenic purpura.

**INITIAL COVERAGE CRITERIA**<sup>7 8 32</sup>

1. Plasmapheresis may be considered medically necessary as a first line therapy for any category I condition as outlined by the American Society for Apheresis that includes but is not limited to the following:
  - Acute inflammatory demyelinating polyneuropathy (Guillain-Barré syndrome)
  - ANCA-associated rapidly progressive glomerulonephritis (granulomatosis with polyangiitis [Wegener's]):
    - o Dialysis dependence; or
    - o Diffuse alveolar hemorrhage
  - Anti-glomerular basement membrane disease (Goodpasture's syndrome)

- Dialysis independence; or
  - Diffuse alveolar hemorrhage
- Chronic inflammatory demyelinating polyradiculoneuropathy
- Cryoglobulinemia:
  - Severe/symptomatic
- Focal segmental glomerulosclerosis:
  - Recurrent in transplanted kidney
- Hemolytic-uremic syndrome:
  - Atypical HUS due to autoantibody to factor H
- Hyperviscosity in monoclonal gammopathies:
  - Prophylaxis for rituximab; or
  - Treatment of symptoms
- Liver transplantation, ABO incompatible:
  - Desensitization, living donor
- Myasthenia gravis:
  - Moderate-severe; or
  - Pre-thymectomy
- PANDAS (exacerbation)
- Paraproteinemic polyneuropathies:
  - IgG/IgA; or
  - IgM
- Renal transplantation, ABO compatible:
  - Antibody-mediated rejection; or
  - Desensitization, living donor, positive crossmatch due to donor-specific HLA antibody
- Renal transplantation, ABO incompatible:
  - Desensitization, living donor
- Sydenham's chorea
- Thrombotic microangiopathy, drug-associated:
  - Ticlopidine
- Thrombotic thrombocytopenic purpura
- Wilson disease, fulminant

2. Plasmapheresis may be considered medically necessary adjunctive secondary therapy category II condition as outlined by the American Society for Apheresis when response to conventional therapy (e.g., corticosteroids or intravenous immunoglobulins [IVIG]) has failed that includes but is not limited to the following:

- Acute disseminated encephalomyelitis
- Antiphospholipid syndrome, catastrophic
- Autoimmune hemolytic anemia:
  - Cold agglutinin disease (life-threatening)
- Familial hypercholesterolemia:

- Homozygotes with small blood volume
- ❑ Hematopoietic cell transplantation, major ABO incompatibility (recipient has anti-A or anti-B antibodies):
  - Bone marrow stem cells; or
  - Peripheral blood stem cells
- ❑ Hemolytic-uremic syndrome:
  - Atypical HUS due to complement factor gene mutations
- ❑ Lambert-Eaton myasthenic syndrome
- ❑ Multiple sclerosis:
  - Acute CNS inflammatory demyelinating disease
- ❑ Myeloma cast nephropathy
- ❑ Neuromyelitis optica (Devic's syndrome), acute
- ❑ Overdose, venoms, and poisoning:
  - Mushroom poisoning
- ❑ Phytanic acid storage disease (Refsum's disease)
- ❑ Renal transplantation, ABO incompatibility:
  - Humoral rejection
- ❑ Systemic lupus erythematosus, severe (eg, cerebritis, diffuse alveolar hemorrhage)
- ❑ Voltage gated potassium channel antibodies

#### COVERAGE EXCLUSIONS<sup>7 8 32</sup>

Plasmapheresis is considered experimental and investigational for all other indications because the medical literature does not support the clinical efficacy that includes any category III or IV condition as outlined by the American Society for Apheresis.

#### SUMMARY OF MEDICAL EVIDENCE<sup>9-30</sup>

##### Renal Indications:

Baweja and associates (2011) performed a systematic review of recent and past evidence and the current indications for treatment in renal disease. Recently, results from several randomized controlled trials, meta-analyses, and prospective studies have shown plasmapheresis may be of benefit in various renal diseases, and have provided insights into more rational use of this therapy. A multicenter trial by the European Vasculitis Study Group has shown it is the preferred additional form of therapy for patients with anti-neutrophil cytoplasmic antibody-associated glomerulonephritis and severe renal failure. A recent study conducted at Mayo Clinic also found it effective at reversing renal failure from myeloma-related cast nephropathy if serum free light chain levels were reduced by at least 50%. In addition, a Cochrane review has analyzed the available evidence for its use in thrombotic thrombocytopenic purpura and hemolytic uremic syndrome.<sup>17</sup>

Walsh and associates (2011) performed a systematic review and meta-analysis of randomized controlled trials of plasma exchange in adults with idiopathic renal vasculitis or rapidly progressive glomerulonephritis. Randomized controlled trials that compared standard care with standard care plus adjuvant plasma exchange in adult patients with either renal vasculitis or idiopathic rapidly progressive glomerulonephritis were reviewed. 9

trials including 387 patients were found. In a fixed-effects model, the pooled RR for end-stage renal disease or death was 0.80 for patients treated with adjunctive plasma exchange compared with standard care alone (95% CI, 0.65-0.99;  $P = 0.04$ ). No significant heterogeneity was detected ( $P = 0.5$ ;  $I(2) = 0\%$ ). The effect of plasma exchange did not differ significantly across the range of baseline serum creatinine values ( $P = 0.7$ ) or number of plasma exchange treatments ( $P = 0.8$ ). The RR for end-stage renal disease was 0.64 (95% CI, 0.47-0.88;  $P = 0.006$ ), whereas the RR for death alone was 1.01 (95% CI, 0.71-1.4;  $P = 0.9$ ). The reviewers concluded that plasma exchange may decrease the composite end point of end-stage renal disease or death in patients with renal vasculitis.<sup>25</sup>

Cui and colleagues (2011) conducted a retrospective survey of 221 consecutive patients seen from 1998 to 2008 in one hospital and reported on the patient and renal survival and the risk factors affecting the outcomes. The effects of 3 different treatment regimens were compared: 1) combination therapy of plasmapheresis and immunosuppression, 2) steroids and cytotoxic agents, and 3) steroids alone. The patient and renal survival rates were 72.7% and 25.0%, respectively, at 1 year after disease presentation. The serum level of anti-GBM antibodies (increased by 20 U/mL; hazard ratio [HR], 1.16;  $p = 0.009$ ) and the presentation of positive antineutrophil cytoplasmic antibodies (ANCA) (HR, 2.18;  $p = 0.028$ ) were independent predictors for patient death. The serum creatinine at presentation (doubling from 1.5 mg/dL; HR, 2.07;  $p < 0.001$ ) was an independent predictor for renal failure. The combination therapy of plasmapheresis plus corticosteroids and cyclophosphamide had an overall beneficial effect on both patient survival (HR for patient mortality, 0.31;  $p = 0.001$ ) and renal survival (HR for renal failure, 0.60;  $p = 0.032$ ), particularly patient survival for those with Goodpasture syndrome (HR for patient mortality, 0.29;  $p = 0.004$ ) and renal survival for those with anti-GBM nephritis with initial serum creatinine over 6.8 mg/dL (HR for renal failure, 0.52;  $p = 0.014$ ). The treatment with corticosteroids plus cyclophosphamide was found not to improve the renal outcome of disease ( $p = 0.73$ ). In conclusion, the combination therapy was preferred for patients with anti-GBM disease, especially those with pulmonary hemorrhage or severe renal damage. Early diagnosis was crucial to improving outcomes.<sup>27</sup>

Walters and associates (2010) conducted systematic review to determine the benefits and harms of any intervention for the treatment of renal vasculitis in adults. Statistical analyses were performed using a random effects model and results expressed as risk ratio with 95% confidence intervals for dichotomous outcomes or mean difference for continuous outcomes. Twenty two studies (1674 patients) were included. Plasma exchange as adjunctive therapy significantly reduces the risk of end-stage kidney disease at 12 months (five studies: RR 0.47, CI 0.30 to 0.75). Four studies compared the use of pulse and continuous administration of cyclophosphamide. Remission rates were equivalent but pulse treatment causes an increased risk of relapse (4 studies: RR 1.79, CI 1.11 to 2.87) compared with continuous cyclophosphamide. Azathioprine has equivalent efficacy as a maintenance agent to cyclophosphamide with fewer episodes of leukopenia. Mycophenolate mofetil may be equivalent to cyclophosphamide as an induction agent but resulted in a higher relapse rate when tested against Azathioprine in remission maintenance. Rituximab is an effective remission induction agent. Methotrexate or Leflunomide are potential choices in remission maintenance therapy. Oral co-trimoxazole did not reduce relapses significantly in Wegener's granulomatosis. The authors concluded that plasma exchange is effective in patients with severe ARF secondary to vasculitis. Pulse cyclophosphamide results in an increased risk of relapse when compared to continuous oral use but a reduced total dose. Whilst cyclophosphamide is standard induction treatment, rituximab and mycophenolate mofetil are also effective. Azathioprine,

methotrexate and leflunomide are effective as maintenance therapy. Further studies are required to more clearly delineate the appropriate place of newer agents within an evidence-based therapeutic strategy.<sup>26</sup>

Gupta and colleagues performed a systematic review (2010) of three randomized controlled trials (RCTs) and multiple observational trials to evaluate the potential role of plasmapheresis in the management of multiple myeloma complicated by acute renal failure. This systematic review presents the results of these trials regarding survival benefits, recovery from dialysis, and improvement in renal function. A comprehensive search revealed 56 articles. Of these, only 8 articles met inclusion criteria (3 RCTs, 1 correction of results, and 4 observational trials). Two of the 3 RCTs showed no difference in survival benefit. Two of the 3 RCTs showed a greater percentage of patients stopping dialysis in the intervention group; however, these results were not reproduced in the largest trial. All the studies showed an improvement in renal function for patients receiving plasmapheresis; however, only 2 RCTs and 1 retrospective study showed a statistically significant improvement in renal function among patients who received plasmapheresis in comparison with a control group. The authors concluded that this systematic review does not suggest a benefit of plasmapheresis independent of chemotherapy for multiple myeloma patients with acute renal failure in terms of overall survival, recovery from dialysis, or improvement in renal function.<sup>19</sup>

Tobian and associates (2008) performed a systematic review to evaluate the role of therapeutic plasma exchange (TPE) to remove ABO antibodies and permit ABO-incompatible (ABO-I) kidney transplants. The TPE treatment plan is based on ABO titers with the goal of a titer of 16 or less at the anti-human globulin (AHG) phase before surgery. Pretransplant therapy consists of every-other-day TPE followed immediately by cytomegalovirus hyperimmune globulin. ABO antibody titers are closely monitored before and after transplantation. After transplantation, TPE therapy is performed for all patients to prevent rebound of anti-A and anti-B titers until tolerance or accommodation occurs. TPE is discontinued and reinstated based on the clinical criteria of creatinine levels, biopsy results, and ABO titer. Fifty-three ABO-I kidney transplants have been completed with no episodes of hyperacute antibody-mediated rejection (AMR) and only three episodes of AMR. One-year death-censored graft survival is 100 percent and patient survival is 97.6 percent. The review concluded that while randomized clinical trials are needed to evaluate the optimal method and protocol to remove ABO antibodies, the current literature and our results indicate a critical role for TPE in ABO-I renal transplantation.<sup>21</sup>

#### *Non-renal Indications:*

Huang and colleagues (2012) performed a prospective randomized controlled study to compare the therapeutic effect of molecular adsorbent re-circulating system (MARS) treatment (MARS group, n=60) with that of plasma exchange (PE) combined with MARS treatment (PE+MARS group, n=60) in patients with liver failure complicated with hepatic encephalopathy. The serum total bilirubin and blood ammonia levels were significantly decreased compared with pretreatment levels after 3 days of both the MARS treatment (p=0.0001, p<0.001) and PE+MARS treatment (both p<0.0001) and the Glasgow coma scale score was significantly increased (both p<0.0001). The 30-day mortality rate was 10.0% (6/60) in the MARS group and 11.7% (7/60) in the PE + MARS group. The per capita cost of treatment was significantly lower in the PE + MARS group than in the MARS group (p=0.0003). The authors concluded that both MARS and PE + MARS therapy can safely and effectively be used to treat liver failure complicated with hepatic encephalopathy, but PE + MARS therapy reduces serum total bilirubin level more effectively and is more cost-effective.<sup>23</sup>

Weiss and associates (2012) conducted an 8-year retrospective cohort study of children ( $\leq 18$  years) with an international classification of diseases-9-clinical modification (ICD-9-CM) discharge diagnosis indicating an ASFA Category I or II condition, or a procedure code indicating receipt of TPE during hospitalization. Results: TPE was performed during 4,190 hospitalizations of 3,449 patients, of whom 310 (9.0%) and 77 (2.2%) had a primary discharge diagnosis of an ASFA Category I or II condition, respectively. Rates of TPE use for Category I conditions were highest for children with thrombotic thrombocytopenic purpura (TTP), Goodpasture's syndrome, and myasthenia gravis. TPE use in children's hospitals significantly increased from 2003 to 2010, but TPE was performed during only 13.4 and 9.3% of hospitalizations for ASFA Category I and II conditions, respectively. There was significant between-hospital variation in the use of TPE for Category I conditions as a group and individual Category I conditions including TTP. The authors found low levels of TPE use across hospitals for key indications, including TTP, a condition for which TPE is considered a first-line and life-saving procedure. The variation identified may contribute to varying clinical outcomes between hospitals, warrants further investigation, and represents an important opportunity to improve quality of care.<sup>28</sup>

El-Bayoumi and colleagues (2011) performed prospective randomized study to compare the outcome of intravenous immunoglobulin (IVIG) and plasma exchange (PE) treatment in children with Guillain Barré syndrome (GBS) requiring mechanical ventilation. Forty-one children with GBS requiring endotracheal mechanical ventilation (MV) within 14 days from disease onset were included. The ages of the children ranged from 49 to 143 months. Randomly, 20 children received a five-day course of IVIG (0.4 g/kg/day) and 21 children received a five-day course of one volume PE daily. Lumbar puncture (LP) was performed in 36 patients (18 in each group). Both groups had comparable age ( $p = 0.764$ ), weight ( $p = 0.764$ ), duration of illness prior to MV ( $p = 0.854$ ), preceding diarrhea ( $p = 0.751$ ), cranial nerve involvement ( $p = 0.756$ ), muscle power using Medical Research Council (MRC) sum score ( $p = 0.266$ ) and cerebrospinal fluid (CSF) protein ( $p = 0.606$ ). Children in the PE group had a shorter period of MV (median 11 days, IQR 11.0 to 13.0) compared to IVIG group (median 13 days, IQR 11.3 to 14.5) with  $p = 0.037$ . Those in the PE group had a tendency for a shorter Pediatric Intensive Care Unit (PICU) stay ( $p = 0.094$ ). A total of 20/21 (95.2%) and 18/20 (90%) children in the PE and IVIG groups respectively could walk unaided within four weeks after PICU discharge ( $p = 0.606$ ). There was a negative correlation between CSF protein and duration of mechanical ventilation in the PE group ( $p = 0.037$ ), but not in the IVIG group ( $p = 0.132$ ). The authors concluded that in children with GBS requiring MV, PE is superior to IVIG regarding the duration of MV but not PICU stay or the short term neurological outcome. The negative correlation between CSF protein values and duration of MV in PE group requires further evaluation of its clinical usefulness.<sup>24</sup>

Martin and associates (2011) conducted a systematic review to evaluate the safety and efficacy of interventions for pemphigus vulgaris and pemphigus foliaceus. Randomized controlled trials including participants with the diagnosis of pemphigus vulgaris or pemphigus foliaceus confirmed with clinical, histopathological, and immunofluorescence criteria were selected. All interventions were considered. Primary outcomes studied were remission and mortality. Secondary outcomes included disease control, relapse, pemphigus severity score, time to disease control, cumulative glucocorticoid dose, serum antibody titers, adverse events, and quality of life. Eleven studies with a total of 404 participants were identified. Interventions assessed included prednisolone dose regimen, pulsed dexamethasone, azathioprine, cyclophosphamide, cyclosporine, dapsone, mycophenolate, plasma exchange, topical epidermal growth factor, and traditional Chinese medicine. We found some interventions to be superior for certain outcomes, although we were unable to conclude which treatments are

superior overall. The authors concluded that there is inadequate evidence available at present to ascertain the optimal therapy for pemphigus vulgaris and pemphigus foliaceus. Further randomized controlled trials are required.<sup>30</sup>

Liu and colleagues (2010) performed a randomized controlled trial to investigate the effects of double-filtration plasmapheresis (DFPP), immunoadsorption (IA) and intravenous immunoglobulin (IVIg) in the treatment of late-onset myasthenia gravis (MG). A total of 40 late-onset MG patients were randomly divided into three groups: 15 patients were treated with DFPP; 10 patients were treated with IA; and 15 patients received IVIg. The titers of titin antibodies (Titin-ab), acetylcholine receptor antibodies (AChR-ab), presynaptic membrane antibody (Prsm-ab) were detected before and after the treatment, and the quantitative MG score (QMG score) was assessed by blinded examiners before and immediately after the entire course of treatment. The clinical efficacy, duration of respiratory support, hospital stay, and the correlation between the three antibodies and the QMG score were also analyzed. Compared to pre-treatment, the values of Titin-ab, AChR-ab, and PrsmR-ab were all dramatically decreased ( $P < 0.05$ ); meanwhile the value of Titin-ab in the DFPP and IA groups decreased much more than in the IVIg group ( $P < 0.01$ ); however, no statistical difference was found between the DFPP and IA groups ( $P > 0.05$ ). Although the QMG score significantly improved in all three groups, it decreased much more in both the DFPP and IA groups than that in the IVIg group ( $P < 0.01$ ). Symptoms were also effectively ameliorated by all treatments, but the clinical efficacy of the DFPP and IA groups was higher than the IVIg group ( $P < 0.05$ ), as was the remission time ( $P < 0.01$ ), the duration of hospital stay ( $P < 0.05$ ), and the number of respiratory supports required ( $P < 0.05$ ). Using Pearson's correlation, the decrease of Titin-ab showed a longitudinal correlation with the decrease of QMG score ( $r = 0.6107$ ,  $P < 0.01$ ). The authors concluded that both DFPP and IA showed better short-term clinical effectiveness than immunoglobulin transfusion, rapidly and effectively clearing the pathogenic antibodies in late-onset MG patients, especially for Titin-ab.<sup>22</sup>

Zechmeister and associates (2009) performed a systematic review to evaluate apheresis in patients with familial hypercholesterolemia who are resistant to drug therapy and whether the various apheresis techniques available result in relevant improvement of clinical endpoints (cardiovascular morbidity and mortality, quality of life). Evidence from the ten studies included weakly indicates an improvement in angina symptoms and reduced mortality. However, due to limited study quality, no reliable answers are possible concerning the question whether LDL apheresis results in reduced cardiovascular morbidity/mortality or improved quality of life. The review concluded that the available evidence indicates a possible net benefit of LDL apheresis. However, since the quality of the evidence is very low, treatment should be strictly restricted to patients with severe familial hypercholesterolemia who are resistant to standard care.<sup>20</sup>

Bonnan and colleagues (2009) retrospectively studied the outcome of plasma exchange (PE) treated versus steroid-only treated spinal attacks in relapsing neuromyelitis optica (NMO) and extensive transverse myelitis (ETM). Ninety-six severe spinal attacks in 43 Afro-Caribbean patients were included in the study. PE was given as an add-on therapy in 29 attacks. Expanded disability status score (EDSS) was obtained before attack, during the acute and residual stage. We defined the DeltaEDSS as the rise from basal to residual EDSS. The DeltaEDSS was found to be lower in the PE-treated group ( $1.2 \pm 1.6$  vs  $2.6 \pm 2.3$ ;  $P < 0.01$ ). A low basal impairment is associated with a better outcome. Improvement was obtained in both NMO-IgG negative and positive NMO attacks. Minor adverse events manifested in seven PE sessions (24%). The authors concluded PE

appears to be a safe add-on therapy that may be employed early in severe spinal attacks in the NMO spectrum disorders in order to maximize improvement rate. PE efficiency is independent of NMO-IgG positivity.<sup>15</sup>

Kaynar and colleagues (2008) performed a retrospective review of the medical records of 57 neurological patients consecutively treated with therapeutic plasma exchange (TPE). TPE indications in neurological diseases included Guillain-Barré Syndrome (GBS) (n=41), myasthenia gravis (MG) (n=11), acute disseminated encephalomyelitis (ADEM) (n=3), chronic inflammatory demyelinating polyneuropathy (CIDP) (n=1) and multiple sclerosis (MS) (n=1). Patient median age was 49; there was a predominance of males. Twenty-two patients had a history of other therapy including intravenous immunoglobulin (IVIG), steroid, azathioprin, and pridostigmine prior to TPE. Another 35 patients had not received any treatment prior to TPE. All patients were classified according to the Hughes functional grading scores pre- and first day post-TPE for early clinical evaluation of patients. The TPE was carried out 1-1.5 times at the predicted plasma volume every other day. Two hundred and ninety-four procedures were performed on 57 patients. The median number of TPE sessions per patient was five, and the median processed plasma volume was 3075mL for each cycle. Although the pre-TPE median Hughes score of all patients was 4, it had decreased to grade 1 after TPE. While the pre-TPE median Hughes score for GBS and MG patients was 4, post-TPE scores were decreased to grade 1. Additionally, there was a statistically significant difference between post-TPE Hughes score for GBS patients with TPE as front line therapy and patients receiving IVIG as front line therapy (1 vs. 3.5; p=0.034). Although there was no post-TPE improvement in Hughes scores in patients with ADEM and CIDP, patients with MS had an improved Hughes score from 4 to 1. Mild and manageable complications such as hypotension and hypocalcemia were also observed. The authors concluded TPE may be preferable for controlling symptoms of neuroimmunological disorders in early stage of the disease, especially with GBS.<sup>16</sup>

Ruma and associates (2007) conducted a retrospective multicenter case series. Patients with a history of early second-trimester fetal loss secondary to severe maternal red cell alloimmunization or patients with markedly elevated maternal antired cell titers felt to be consistent with poor fetal outcome were offered treatment. Therapy consisted of serial plasmapheresis followed by weekly infusions of intravenous immune globulin (IVIG). Maternal titers were measured before and after plasmapheresis. Pregnant patients with either a history of a previous perinatal loss (n = 7) or markedly elevated maternal antibody titers (n = 2) were treated with combined plasmapheresis and IVIG. All 9 fetuses subsequently required intrauterine transfusions (median 4; range 3-8). All infants survived with a mean gestational age at delivery of 34 weeks (range 26-38 weeks). Maternal antired cell titers were significantly reduced after plasmapheresis (P < .01) and remained decreased during IVIG therapy. Serial peak middle cerebral artery velocities remained below the threshold for moderate to severe fetal anemia during therapy. The authors concluded that combined immunomodulation with plasmapheresis and IVIG represents a successful approach to the treatment of severe maternal red cell alloimmunization.<sup>29</sup>

There are several Cochrane reports available on plasma exchange for various diseases as outlined below:<sup>9-14 18</sup>

- Guillain-Barré syndrome: There is moderate-quality evidence that shows significantly more improvement with plasma exchange than supportive care alone in adults with Guillain-Barré syndrome without a significant increase in serious adverse events.

- Haemolytic uraemic syndrome and thrombotic thrombocytopenic purpura: PE with FFP is still the most effective treatment available for TTP.
- Myasthenia gravis: Many studies with case series report short-term benefit from plasma exchange in myasthenia gravis, especially in myasthenic crisis
- Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP): Moderate to high quality evidence from two small trials showed that plasma exchange provides significant short-term improvement in disability, clinical impairment and motor nerve conduction velocity in CIDP but rapid deterioration may occur afterwards.
- Treatment for IgG and IgA paraproteinaemic neuropathy: Modest short-term benefit of plasma exchange in IgG or IgA paraproteinaemic neuropathy, over a short follow-up period, when compared to sham plasma exchange.
- Renal vasculitis: Plasma exchange is effective in patients with severe ARF secondary to vasculitis.
- Bullous pemphigoid (BP): The effectiveness of adding plasma exchange, azathioprine or mycophenolate mofetil to corticosteroids, and combination treatment with tetracycline and nicotinamide needs further investigation.

Professional Organizations <sup>3-8</sup>

American Society for Apheresis (ASA): In 2013, the ASA published the sixth special edition <sup>8</sup> of evidence-based guidelines for the practice of apheresis medicine. They classified the indications for apheresis into four categories (I-IV) based on the quality of the evidence and the strength of recommendations derived from the evidence. These categories rate the indications for PP by condition and include the following:

- Category I - “Disorders for which apheresis is accepted as first-line therapy, either as a primary standalone treatment or in conjunction with other modes of treatment. [Example: plasma exchange in Guillain-Barre´ syndrome as first-line standalone therapy; plasma exchange in myasthenia gravis as first-line in conjunction with immunosuppression and cholinesterase inhibition]”.
- Category II – “Disorders for which apheresis is accepted as second-line therapy, either as a standalone treatment or in conjunction with other modes of treatment. [Example: plasma exchange as standalone secondary treatment for acute disseminated encephalomyelitis after high-dose IV corticosteroid failure; extracorporeal photopheresis added to corticosteroids for unresponsive chronic graft-versus-host disease]”.
- Category III – “Optimum role of apheresis therapy is not established. Decision making should be individualized. [Example: extracorporeal photopheresis for nephrogenic systemic fibrosis; plasma exchange in patients with sepsis and multiorgan failure]”.
- Category IV – “Disorders in which published evidence demonstrates or suggests apheresis to be ineffective or harmful. IRB approval is desirable if apheresis treatment is undertaken in these circumstances. [Example: plasma exchange for active rheumatoid arthritis]”.

**CODING INFORMATION:** THE CODES LISTED IN THIS POLICY ARE FOR REFERENCE PURPOSES ONLY. LISTING OF A SERVICE OR DEVICE CODE IN THIS POLICY DOES NOT IMPLY THAT THE SERVICE DESCRIBED BY THIS CODE IS COVERED OR NON-COVERED. COVERAGE IS DETERMINED BY THE BENEFIT DOCUMENT. THIS LIST OF CODES MAY NOT BE ALL INCLUSIVE.

CPT	Description
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36514	Therapeutic apheresis; for plasmapheresis
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HCPCS	Description
S2120	Low density lipoprotein (LDL) apheresis using heparin-induced extracorporeal LDL precipitation

#### RESOURCE REFERENCES

##### Government Agency

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##### Professional Society Guidelines

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##### Peer Reviewed Publications

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**Revision/Review History:** 3/8/18: Policy reviewed and no changes have been made to the criteria.