



## FEP Medical Policy Manual

### FEP 1.01.29 Tumor Treating Fields Therapy

**Effective Policy Date: October 1, 2022**

**Original Policy Date: September 2013**

**Related Policies:**

8.01.08 - Intraoperative Radiotherapy

8.01.59 - Intensity-Modulated Radiotherapy: Central Nervous System Tumors

## Tumor Treating Fields Therapy

### Description

#### Description

Tumor treating fields (TTF) therapy is a noninvasive technology intended to treat glioblastoma and malignant pleural mesothelioma on an outpatient basis and at home using electrical fields. Glioblastoma multiforme (GBM) is the most common and deadly malignant brain tumor. It has a very poor prognosis and is associated with low quality of life during treatment. Malignant pleural mesothelioma is an aggressive tumor with few treatment options that is associated with significant morbidity and mortality.

#### OBJECTIVE

The objective of this evidence review is to determine whether the use of tumor treating fields therapy improves the net health outcome for patients with solid tumors including glioblastoma multiforme and malignant pleural mesothelioma.

## POLICY STATEMENT

Tumor treating fields therapy to treat glioblastoma multiforme (GBM) is considered **medically necessary** as an adjunct to standard maintenance therapy with temozolomide in individuals with newly diagnosed GBM following initial treatment with surgery, radiotherapy, and/or chemotherapy under the following conditions:

- Individuals  $\geq 18$  years of age,
- Supratentorial tumor,
- Karnofsky Performance Status score  $\geq 70\%$ ,
- Individual understands device use, including the requirement for a shaved head, and is willing to comply with use criteria according to the U.S. Food and Drug Administration label (see Policy Guidelines).

Tumor treating fields therapy is considered **not medically necessary** in all other conditions, including but not limited to the following situations:

- As an adjunct to standard medical therapy (eg, bevacizumab, chemotherapy) for individuals with progressive or recurrent GBM,
- As an alternative to standard medical therapy for individuals with progressive or recurrent GBM,
- For brain metastases,
- For cancer in areas other than the brain,
- As an adjunct to standard medical therapy (pemetrexed and platinum-based chemotherapy) for individuals with malignant pleural mesothelioma.

## POLICY GUIDELINES

Progression was defined in the EF-14 trial (Stupp et al [2015, 2017]) according to the MacDonald criteria (tumor growth  $>25\%$  compared with the smallest tumor area measured in the individual during the trial or appearance of 1 or more new tumors in the brain that are diagnosed radiologically as glioblastoma multiforme).

The U.S. Food and Drug Administration label includes the following notices:

- Individuals should use Optune for at least 18 hours a day to get the best response to treatment.
- Individuals should finish at least 4 full weeks of therapy to get the best response to treatment. Stopping treatment before 4 weeks lowers the chances of a response to treatment.

## BENEFIT APPLICATION

Experimental or investigational procedures, treatments, drugs, or devices are not covered (See General Exclusion Section of brochure).

## FDA REGULATORY STATUS

In April 2011, the NovoTTF-100A™ System (Novocure; assigned the generic name of TTF) was approved by the U.S. Food and Drug Administration (FDA) through the premarket approval process.<sup>5</sup> The FDA approved label reads as follows: "The NovoTTF-100A System is intended as a treatment for adult patients (22 years of age or older) with confirmed GBM, following confirmed recurrence in an upper region of the brain (supratentorial) after receiving chemotherapy. The device is intended to be used as a stand-alone treatment and is intended as an alternative to standard medical therapy for recurrent GBM after surgical and radiation options have been exhausted."

In September 2014, FDA approved Novocure's request for a product name change from NovoTTF-110A System to Optune.<sup>6</sup>

In October 2015, FDA expanded the indication for Optune in combination with temozolomide to include newly diagnosed GBM.<sup>7</sup> The device was granted priority review status in May 2015 because there was no legally marketed alternative device available for the treatment of newly diagnosed GBM, a life-threatening condition. In July 2016, a smaller, lighter version of the Optune device, called the Optune System (NovoTTF-200A System), received FDA approval.

The FDA-approved label for newly diagnosed GBM reads as follows: "This device is indicated as treatment for adult patients (22 years of age or older) with histologically-confirmed glioblastoma multiforme (GBM). Optune with temozolomide is indicated for the treatment of adult patients with newly diagnosed, supratentorial glioblastoma following maximal debulking surgery and completion of radiation therapy together with concomitant standard of care chemotherapy."

In May 2019, the FDA approved a modified version of the Optune System (NovoTTF-100A System), which is now called the Optune Lua™ System (NovoTTF™-100L System), for "treatment of adult patients with unresectable, locally advanced or metastatic, malignant pleural mesothelioma (MPM) to be used concurrently with pemetrexed and platinum-based chemotherapy. The indication was modified from that granted for the Humanitarian Device Exemption designation to more clearly identify the patient population the device is intended to treat and in which the safety and probable benefit of the device is supported by the available clinical data."<sup>8</sup>

In September 2021, the FDA granted breakthrough designation to the NovoTTF-200T System for use together with atezolizumab and bevacizumab for the first-line treatment of patients with unresectable or metastatic liver cancer.<sup>9</sup>

To date, all of the existing tumor treating fields products fall under the brand name Optune. In March 2020, the manufacturer of Optune products announced a plan to include a suffix after the brand name for newly approved indications to further delineate specific indications for individual products (eg, Optune Lua).<sup>10</sup>

## RATIONALE

### Summary of Evidence

For individuals who have newly diagnosed glioblastoma multiforme (GBM) on maintenance therapy after initial treatment who receive tumor treating fields (TTF) therapy as an adjunct to standard maintenance therapy, the evidence includes an randomized controlled trial (RCT) and a systematic review. Relevant outcomes include OS, disease-specific survival, symptoms, functional outcomes, quality of life, and treatment-related morbidity. The EF-14 trial found a significant increase of 2.7 months in progression-free survival (PFS) and an increase of 4.9 months in overall survival (OS) with the addition of TTF therapy to standard maintenance therapy (ie, temozolomide) in patients with newly diagnosed GBM. Although patients were not blinded to treatment assignment, progression-free survival (PFS) was assessed by blinded evaluators, and the placebo effects on the objective measure of OS are expected to be minimal. In a systematic review that included the EF-14 trial along with other observational studies, the pooled median OS and PFS in newly diagnosed patients who received TTF therapy was 21.7 months and 7.2 months, respectively. This technology represents a clinically significant option in the treatment of patients with GBM, for whom options are limited. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have progressive or recurrent GBM who receive TTF therapy as an adjunct or alternative to standard medical therapy, the evidence includes an RCT, nonrandomized comparative studies, and a systematic review of these data. Relevant outcomes are OS, disease-specific survival, quality of life, and treatment-related morbidity. The single RCT evaluating TTF therapy for recurrent GBM did not show superiority of TTF therapy for the primary outcome (OS) compared with physicians' choice chemotherapy. Because no serious adverse effects have been identified with TTF therapy, this raises the possibility that treatment with TTF might reduce the toxicity associated with treatment for recurrent GBM. A reduction in chemotherapy-associated toxicity without loss of efficacy would be considered a net health benefit. However, this RCT is not sufficient to permit conclusions on the efficacy of the device. Because the trial was not designed as a noninferiority trial, no inferences of noninferiority compared with chemotherapy can be made. Also, quality of life assessment was measured in an insufficient number of patients to reach firm conclusions on differences in quality of life between TTF therapy and medical treatment. The highest quality study of TTF combined with medical treatment for recurrent GBM is a post hoc analysis of the EF-14 trial. In a systematic review that included the RCT and post hoc analysis of the EF-14 trial, along with other observational studies, the pooled median OS and PFS in patients with recurrent GBM who received TTF therapy was 10.3 months and 5.7 months, respectively. A high-quality, prospective RCT is needed. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have unresectable, locally advanced or metastatic, malignant pleural mesothelioma (MPM) who receive TTF therapy as an adjunct to standard maintenance therapy, the evidence includes a single-arm prospective study conducted in 80 patients and a retrospective study of 5 US patients. Relevant outcomes include OS, disease-specific survival, symptoms, functional outcomes, quality of life, and treatment-related morbidity. In patients who received TTF therapy in combination with pemetrexed and cisplatin or carboplatin, median OS was 18.2 months (95% CI, 12.1 to 25.8 months). Because there was no comparison group, it is not possible to make conclusions about the effectiveness of the intervention compared to medical therapy alone. The retrospective study is the first publication of real-world implementation of TTF for MPM. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

## SUPPLEMENTAL INFORMATION

### Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

#### National Comprehensive Cancer Network

National Comprehensive Cancer Network guidelines on central nervous system cancers ( v.2.2021) include recommendations for the treatment of glioblastoma (see Table 1).<sup>3</sup> For the initial treatment of patients with glioblastoma with good performance status and either methylated or unmethylated or indeterminate O<sup>6</sup>-methylguanine-DNA methyltransferase promotor status, treatment with standard brain radiotherapy plus concurrent temozolomide and adjuvant temozolomide plus alternating electric field therapy is a category 1 recommendation. Alternating electric currents therapy is only an option for patients with supratentorial disease. Consideration of alternating electric field therapy for recurrent glioblastoma is a category 2B recommendation.

**Table 1. Guidelines for Adjuvant Treatment of Glioblastoma, by Age and Performance Status**

Age, y	KPS Score,%	Treatment Options	Category
≤70	≥60	<ul style="list-style-type: none"> <li>Standard RT plus concurrent and adjuvant temozolomide plus TTF</li> <li>Standard RT plus concurrent and adjuvant temozolomide</li> </ul>	1
≤70	<60	<ul style="list-style-type: none"> <li>Hypofractionated RT with/without concurrent or adjuvant temozolomide</li> <li>Temozolomide</li> <li>Palliative/best supportive care</li> </ul>	2A
>70	≥60	<ul style="list-style-type: none"> <li>Hypofractionated RT plus concurrent and adjuvant temozolomide<sup>a</sup></li> <li>Standard RT plus concurrent and adjuvant temozolomide plus TTF</li> </ul>	1
>70	<60	<ul style="list-style-type: none"> <li>Hypofractionated brain RT alone</li> <li>Temozolomide alone</li> <li>Palliative/best supportive care</li> </ul>	2A

KPS: Karnofsky Performance Status; RT: radiotherapy; TTF: tumor treating fields.

<sup>a</sup> Hypofractionated RT plus concurrent and adjuvant temozolamide is only a Category 1 recommendation in patients with methylated O<sup>6</sup>-methylguanine-DNA methyltransferase promotor status

The National Comprehensive Cancer Network guidelines on malignant pleural mesothelioma ( v.1.2022) do not address tumor treating fields as a treatment option for malignant pleural mesothelioma.<sup>22</sup>

### U.S. Preventive Services Task Force Recommendations

The policies contained in the FEP Medical Policy Manual are developed to assist in administering contractual benefits and do not constitute medical advice. They are not intended to replace or substitute for the independent medical judgment of a practitioner or other health care professional in the treatment of an individual member. The Blue Cross and Blue Shield Association does not intend by the FEP Medical Policy Manual, or by any particular medical policy, to recommend, advocate, encourage or discourage any particular medical technologies. Medical decisions relative to medical technologies are to be made strictly by members/patients in consultation with their health care providers. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that the Blue Cross and Blue Shield Service Benefit Plan covers (or pays for) this service or supply for a particular member.

Not applicable.

## Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

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## POLICY HISTORY - THIS POLICY WAS APPROVED BY THE FEP® PHARMACY AND MEDICAL POLICY COMMITTEE ACCORDING TO THE HISTORY BELOW:

Date	Action	Description
December 2013	New policy	Not medically necessary for all indications.
December 2014	Replace policy	Policy updated with literature review, references 8, 16, and 17 added. Editorial revisions made to rationale section. Policy statement unchanged
December 2015	Replace policy	Policy updated with literature review through July 8, 2015; references 10- 11 removed and 10-12 added. Policy statement unchanged.
March 2017	Replace policy	Policy updated with literature review through July 18, 2016, reference 13 added. Policy statements rewritten for clarity but tumor treating fields remains not medically necessary for all indications.
September 2018	Replace policy	Policy updated with literature review through April 5, 2018; references 10, and 12-13 added. Title changed from "Tumor Treatment Fields Therapy for Glioblastoma" to "Tumor Treating Fields Therapy". May be considered medically necessary in conjunction with maintenance temozolomide for patients with newly diagnosed glioblastoma multiforme. Investigational for all other non-FDA approved indications.
September 2019	Replace policy	Policy updated with literature review through May 29, 2019; reference 17 added. Regulatory Status section updated to include new FDA indication for malignant pleural mesothelioma. Due to FDA PMA status: "investigational" statement changed to "not medically necessary" and malignant pleural mesothelioma added to list of conditions for which the therapy is considered not medically necessary.
September 2020	Replace policy	Policy updated with literature review through June 1, 2020; references added. Regulatory Status section updated to include information differentiating between Optune and Optune Lua products. Policy statements unchanged.
September 2021	Replace policy	Policy updated with literature review through May 28, 2021; no references added. Policy statements unchanged.
September 2022	Replace policy	Policy updated with literature review through May 23, 2022; references added. Minor editorial refinements to policy statements; intent unchanged.

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