



## FEP Medical Policy Manual

### FEP 7.03.02 Allogeneic Pancreas Transplant

**Annual Effective Policy Date: January 1, 2024**

**Original Policy Date: June 2012**

**Related Policies:**

1.01.30 - Artificial Pancreas Device Systems

7.03.01 - Kidney Transplant

7.03.12 - Islet Transplantation

## Allogeneic Pancreas Transplant

### Description

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Transplantation of a healthy pancreas is a treatment for patients with insulin-dependent diabetes. Pancreas transplantation can restore glucose control and prevent, halt, or reverse the secondary complications from diabetes.

#### OBJECTIVE

The objective of this evidence review is to determine whether pancreas transplantation or retransplantation improves the net health outcome in patients with insulin-dependent diabetes compared with standard management without transplantation.

## POLICY STATEMENT

Pancreas transplant after a prior kidney transplant may be considered **medically necessary** in individuals with insulin-dependent diabetes.

A combined pancreas and kidney transplant may be considered **medically necessary** in insulin-dependent diabetic individuals with uremia.

Pancreas transplant alone may be considered **medically necessary** in individuals with severely disabling and potentially life-threatening complications due to hypoglycemia unawareness and labile insulin-dependent diabetes that persists despite optimal medical management.

Pancreas retransplant after a failed primary pancreas transplant may be considered **medically necessary** in individuals who meet criteria for pancreas transplantation.

Pancreas transplant is considered **investigational** in all other situations.

## POLICY GUIDELINES

### General Criteria

Potential contraindications for solid organ transplant that are subject to the judgment of the transplant center include the following:

- Known current malignancy, including metastatic cancer
- Recent malignancy with high risk of recurrence
- Untreated systemic infection making immunosuppression unsafe, including chronic infection
- Other irreversible end-stage diseases not attributed to kidney disease
- History of cancer with a moderate risk of recurrence
- Systemic disease that could be exacerbated by immunosuppression
- Psychosocial conditions or chemical dependency affecting the ability to adhere to therapy.

### Pancreas-Specific Criteria

Candidates for pancreas transplant alone should also meet one of the following severity of illness criteria:

- Documented severe hypoglycemia unawareness as evidenced by chart notes or emergency department visits or
- Documented potentially life-threatening labile diabetes, as evidenced by chart notes or hospitalization for diabetic ketoacidosis.

Additionally, most pancreas transplant individuals will have type 1 diabetes. Those transplant candidates with type 2 diabetes, in addition to being insulin-dependent, should also not be obese (body mass index should be  $\leq 32$  kg/m<sup>2</sup>). In 2018, individuals with type 2 diabetes accounted for 14.8% of all pancreas transplants, according to data from the Organ Procurement and Transplantation Network and the Scientific Registry of Transplant Recipients.<sup>1</sup>

### Multiple Transplant Criteria

Although there are no standard guidelines for multiple pancreas transplants, the following information may aid in case review:

- If there is early graft loss resulting from technical factors (eg, venous thrombosis), a retransplant may generally be performed without substantial additional risk.
- Long-term graft losses may result from chronic rejection, which is associated with increased risk of infection following long-term immunosuppression, and sensitization, which increases the difficulty of finding a negative cross-match. Some transplant centers may wait to allow reconstitution of the immune system before initiating retransplant with an augmented immunosuppression protocol.

## BENEFIT APPLICATION

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

## FDA REGULATORY STATUS

Solid organ transplants are a surgical procedure and, as such, are not subject to regulation by the U.S. Food and Drug Administration (FDA).

The FDA 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. Solid organs used for transplantation are subject to these regulations.

## RATIONALE

### Summary of Evidence

For individuals who have insulin-dependent diabetes who receive a pancreas transplant after a kidney transplant, the evidence includes retrospective studies and registry studies. Relevant outcomes are overall survival (OS), change in disease status, and treatment-related mortality and morbidity. Data from national and international registries have found relatively high patient survival rates with a pancreas transplant after a kidney transplant (eg, a 3-year survival rate of 94.5%). Single-center retrospective studies have found similar patient survival and death-censored pancreas graft survival rates with a pancreas transplant after a kidney transplant or a simultaneous pancreas and kidney (SPK) transplant. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have insulin-dependent diabetes with uremia who receive SPK transplants, the evidence includes retrospective studies and registry studies. Relevant outcomes are OS, change in disease status, and treatment-related mortality and morbidity. Data from national and international registries have found relatively high patient survival rates after SPK transplant. A retrospective analysis found a higher survival rate in patients with type 1 diabetes who had an SPK transplant versus those on a waiting list. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have insulin-dependent diabetes and severe complications who receive pancreas transplant alone, the evidence includes registry studies. Relevant outcomes are OS, change in disease status, and treatment-related mortality and morbidity. Data from international and national registries have found that graft and patient survival rates after pancreas transplant alone have improved over time (eg, 3-year survival of 94.9%). The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have had a prior pancreas transplant who still meet criteria for a pancreas transplant who receive pancreas retransplantation, the evidence includes retrospective studies and registry studies. Relevant outcomes are OS, change in disease status, and treatment-related mortality and morbidity. National data and specific transplant center data have generally found similar graft and patient survival rates after pancreas retransplantation compared with initial transplantation. The evidence is sufficient 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.

## Organ Procurement and Transplantation Network

The Organ Procurement and Transplantation Network updated its comprehensive list of transplant-related policies, most recently in June 2023.<sup>26</sup>

For pancreas registration:

"Each candidate registered on the pancreas waiting list must meet *one* of the following requirements:

- Be diagnosed with diabetes
- Have pancreatic exocrine insufficiency
- Require the procurement or transplantation of a pancreas as part of a multiple organ transplant for technical reasons."

For combined kidney plus pancreas registration: "Each candidate registered on the kidney-pancreas waiting list must be diagnosed with diabetes or have pancreatic exocrine insufficiency with renal insufficiency."

## U.S. Preventive Services Task Force Recommendations

Not applicable.

## Medicare National Coverage

An allogeneic pancreas transplant is covered under Medicare when performed in a facility approved by Medicare as meeting institutional coverage criteria.<sup>33</sup> The Centers for Medicare & Medicaid Services made the following national coverage decision on pancreas transplant for Medicare recipients.<sup>34</sup>

"A. General

Pancreas transplantation is performed to induce an insulin-independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness.

B. Nationally Covered Indications

Effective ... 1999, whole organ pancreas transplantation is nationally covered by Medicare when performed simultaneously with or after a kidney transplant. If the pancreas transplant occurs after the kidney transplant, immunosuppressive therapy begins with the date of discharge from the inpatient stay for the pancreas transplant.

Effective ... 2006, pancreas transplants alone (PA) are reasonable and necessary for Medicare beneficiaries in the following limited circumstances:

1. PA will be limited to those facilities that are Medicare-approved for kidney transplantation.
2. Patients must have a diagnosis of type I diabetes:
  - o Patient with diabetes must be beta-cell autoantibody-positive; or
  - o Patient must demonstrate insulinopenia defined as a fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method. Fasting C-peptide levels will only be considered valid with a concurrently obtained fasting glucose  $\leq 225$  mg/dL;
3. Patients must have a history of medically-uncontrollable labile (brittle) insulin-dependent diabetes mellitus with documented recurrent, severe, acutely life-threatening metabolic complications that require hospitalization. Aforementioned complications include frequent hypoglycemia unawareness or recurring severe ketoacidosis, or recurring severe hypoglycemic attacks;
4. Patients must have been optimally and intensively managed by an endocrinologist for at least 12 months with the most medically recognized advanced insulin formulations and delivery systems;
5. Patients must have the emotional and mental capacity to understand the significant risks associated with surgery and to effectively manage the lifelong need for immunosuppression; and,

6. Patients must otherwise be a suitable candidate for transplantation."

Nationally noncovered indications include "Transplantation of partial pancreatic tissue or islet cells (except in the context of a clinical trial)."

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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
June 2012		
April 2013	Replace policy	Policy updated with literature review. No change to policy statements. References 7, and 14 added; other references renumbered or removed.
June 2014	Replace policy	Policy updated with literature review. Statement on retransplantation modified to state that it applies to patients who meet criteria for pancreas transplant. No changes to policy statement. References updated and renumbered or removed.
June 2015	Replace policy	Policy updated with literature review. References 13, 17, and 22 added. Statement added that pancreas transplant is investigational in all other situations.
December 2017	Replace policy	Policy updated with literature review through June 22, 2017; references 6, 10, 15, and 17 added. Policy statements unchanged.
December 2018	Replace policy	Policy updated with literature review through June 7, 2018; reference 20 added; reference 19 updated. Policy statements unchanged.
December 2019	Replace policy	Policy updated with literature review through June 10, 2019; references added. Policy statements unchanged.
December 2020	Replace policy	Policy updated with literature review through June 24, 2020; references added; Policy statements unchanged.
December 2021	Replace policy	Policy updated with literature review through June 22, 2021; references added; Policy statements unchanged.
December 2022	Replace policy	Policy updated with literature review through June 21, 2022; no references added. Minor editorial refinements to policy statements; intent unchanged.
December 2023	Replace policy	Policy updated with literature review through June 30, 2023; no references added. Policy statements unchanged.

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