Highmark Medical Policy Bulletin

Section:	Injections
Number:	I-13
Topic:	Interferon Alpha
Effective Date:	October 1, 2008
Issued Date:	June 7, 2010
Date Last Reviewed:	

General Policy Guidelines

Indications and Limitations of Coverage

Coverage for interferon is determined according to individual or group customer benefits. Interferon is indicated for the treatment of the following conditions:

- AIDS-related Kaposi's sarcoma
- Bladder carcinoma
- Cervical cancer, advanced
- Chronic hepatitis B Condyloma acuminata
- Hairy cell leukemia
- Hepatitis C
- Malignant melanoma
- Multiple myeloma
- Mycosis fungoides
- Non-hodgkin's lymphoma
- Papillomatosis, laryngeal
- Renal cell cancer as a debulking agent
- Polycythemia vera (when other treatments have failed)
- Chronic phase, Philadelphia chromosome-positive chronic myelogenous leukemia

Interferon alpha used in the treatment of conditions other than those listed above should be denied as not medically necessary and, therefore, not covered. Effective January 26, 2009, a participating, preferred or network provider cannot bill the member for the denied service unless the provider has given advance written notice, informing the member that the service may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, in advance of receiving the service. The signed agreement should be maintained in the provider's records.

NOTE: See Medical Policy Bulletin G-16 for information on Chemotherapy for Malignant Disease.

Description

Interferon alpha (J9213, J9214, J9215, S0145, S0146) is a family of highly hemologous, species-specific proteins that possess antiviral, antineoplastic, and immunomodulating activities. Human interferon alpha is commercially available in the United States as interferon alpha-N3 which is a mixture of naturally occurring human interferon alpha proteins, and as interferon alpha-2a and interferon alpha-2b which are of recombinant DNA origin and exist as single interferon subtype preparations.

NOTE: This policy is designed to address medical guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical circumstances may warrant individual consideration, based on review of applicable medical records.

Procedure Codes

J9213	J9214	J9215	S0145	S0146

Traditional (UCR/Fee Schedule) Guidelines

Refer to General Policy Guidelines

FEP Guidelines

Refer to General Policy Guidelines

Comprehensive / Wraparound / PPO / Major Medical Guidelines

Refer to General Policy Guidelines

Any reference in this bulletin to non-billable services by a network provider may not be applicable to Major Medical.

Managed Care (HMO/POS) Guidelines

Refer to General Policy Guidelines

Publications

PRN References

02/2000, Indications for usage for Interferon Alpha
04/2000, Indications for Interferon Alpha
12/2000, Blue Shield allows Intron A for treating bladder carcinoma

References

Minasian LM, Motzer RJ, Gluck L, Mazumdar M, Vlamis V, Krown SE. Interferon alfa-2a in advanced renal cell carcinoma: treatment results and survival in 159 patients with long-term follow up. *J Clin Oncol*. 1993;11:1368-1375.

Interferons, Alpha, USPDI-Vol. I, Edition 24, 2004, Micromedex, Inc.

Lin SM, Yu ML, Lee CM, et al. Interferon therapy in HBeAg positive chronic hepatitis reduces cirrhosis and hepatocellular carcinoma. *J Hepatol*. October 20, 2006 [E pub ahead of print].

Hudes, G, Carducci M, Tomczak P, et al. Temsirolimus, Interferon alfa, or both for advanced renal-cell carcinoma. *N Engl J Med*. 2007;356:2271-2281.

Eggermont A, Pegylated form of interferon alfa-2b improves recurrence-free survival in melanoma patients. *Lancet*. 2008;372:117-126;89-90.

INTRON® A [package insert]. Kenilworth, NJ: Schering-Plough;Rev. 6/2008.

View Previous Versions

[Version 008 of I-13]
[Version 007 of I-13]
[Version 006 of I-13]
[Version 005 of I-13]
[Version 004 of I-13]
[Version 003 of I-13]
[Version 002 of I-13]
[Version 001 of I-13]

Table Attachment

Text Attachment

Procedure Code Attachments

Diagnosis Codes

042	070.22-070.23	070.32-070.33	070.41
070.44	070.51	070.54	070.70
070.71	078.11	148.9	154.2
154.3	161.0-161.1	161.3-161.9	172.0-172.9
176.0-176.9	180.0-180.9	184.0-184.2	184.4
187.1	187.9	188.0-188.9	189.0-189.1
190.0-190.3	190.5-190.6	190.9	197.3
198.0	198.82	198.89	202.00-202.98
203.00-203.02	205.10-205.11	230.0	231.0
233.1	233.7	233.9	238.4
289.0	776.4		

Glossary

Medical policies do not constitute medical advice, nor are they intended to govern the practice of medicine. They are intended to reflect Highmark's reimbursement and coverage guidelines. Coverage for services may vary for individual members, based on the terms of the benefit contract.