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Azacitidine (Vidaza) [Medicare]

Clinical Policy Bulletins | Medical Clinical Policy Bulletins

Number: 0960m

Commercial CPB (0960.html) | Medicare CPB

Medicare Part B Step Therapy Criteria

Dacogen, **Decitabine**, and **Vidaza**, for the indications listed below:

- Treatment of myelodysplastic syndromes

  Are not covered for new starts, unless the member meets ANY of the following:

  1. Inadequate response to a trial of generic azacitidine
  2. Intolerable adverse event to generic azacitidine
  3. Generic azacitidine is contraindicated for the member.

Policy

I. **Criteria for Initial Approval**

Aetna considers azacitidine (Vidaza) medically necessary for the following indications:

Policy History

Effective: 01/01/2022

Next Review: 03/24/2022

Definitions

Additional Information

Clinical Policy Bulletin Notes

A. Myelodysplastic syndromes (MDS);
B. Acute myeloid leukemia (AML);
C. Accelerated phase or blast phase myelofibrosis;
D. Blastic plasmacytoid dendritic cell neoplasm (BPDCN) when used in combination with venetoclax in *either* of the following settings:

   1. For the treatment of relapsed or refractory disease; *or*
   2. For the treatment of systemic disease with palliative intent;

E. Myelodysplastic syndrome (MDS) / Myeloproliferative Neoplasms (MPN) Overlap Neoplasms - including chronic myelomonocytic leukemia (CMML), BCR-ABL negative atypical chronic myeloid leukemia (aCML), unclassifiable MDS/MPN, or MDS/MPN with ring sideroblasts and thrombocytosis.

Aetna considers all other indications as experimental and investigational.

II. **Continuation of Therapy**

Aetna considers continued azacitidine (Vidaza) therapy medically necessary for members with an indication listed in Section I when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

Dosage and Administration

Azacitidine for injection is available in generic (Actavis Pharma) or brand, Vidaza (Celgene Corp) as lyophilized powder in 100 mg single-dose vials for subcutaneous or intravenous use.

Myelodysplastic Syndromes (MDS)

- The recommended starting dose for the first treatment cycle, for all persons regardless of baseline hematology values, is Vidaza 75 mg/m^2 daily for 7 days to be administered by subcutaneous

injection or intravenous infusion. Premedicate for nausea and vomiting.
- Repeat cycles every 4 weeks. After 2 cycles, may increase dose to 100 mg/m^2 if no beneficial effect is seen and no toxicity other than nausea and vomiting has occurred. Persons should be treated for a minimum of 4 to 6 cycles. Complete or partial response may require additional treatment cycles.

Source: Actavis Pharma, 2020; Celgene Corporation, 2020.

Background

U.S. Food and Drug Administration (FDA)-Approved Indications

Myelodysplastic syndromes (MDS): azacitidine/Vidaza is indicated for treatment of patients with the following French-American-British (FAB) myelodysplastic syndrome subtypes: refractory anemia (RA) or refractory anemia with ringed sideroblasts (if accompanied by neutropenia or thrombocytopenia or requiring transfusions), refractory anemia with excess blasts (RAEB), refractory anemia with excess blasts in transformation (RAEB-T), and chronic myelomonocytic leukemia (CMMoL).

Compendial Uses

- Acute myeloid leukemia (AML)
- Accelerated phase or blast phase myelofibrosis
- Blastic plasmacytoid dendritic cell neoplasm (BPDCN)
- Myelodysplastic syndrome (MDS)/Myeloproliferative Neoplasms (MPN) Overlap Neoplasms

Azacitidine for injection is available as generic or brand, Vidaza. Azacitidine is a nucleoside metabolic inhibitor, a pyrimidine nucleoside analog of cytidine. According to the label, azacitidine for injection is believed to exert its antineoplastic effects by causing hypomethylation of DNA and direct cytotoxicity on abnormal hematopoietic cells in the bone marrow. The concentration of azacitidine required for maximum inhibition

of DNA methylation in vitro does not cause major suppression of DNA synthesis. Hypomethylation may restore normal function to genes that are critical for differentiation and proliferation. The cytotoxic effects of azacitidine cause the death of rapidly dividing cells, including cancer cells that are no longer responsive to normal growth control mechanisms. Non-proliferating cells are relatively insensitive to azacitidine.

Azacitidine carries the following warnings and precautions: anemia, neutropenia, thrombocytopenia, hepatotoxicity, renal toxicity since azacitidine and its metabolites are primarily excreted by the kidneys, tumor lysis syndrome including in patients with MDS, and embryo-fetal risk. The label recommends advising females with reproductive potential of the potential risk to a fetus and to avoid pregnancy.

The most common adverse reactions (>30%) by subcutaneous route include nausea, anemia, thrombocytopenia, vomiting, pyrexia, leukopenia, diarrhea, injection site erythema, constipation, neutropenia and ecchymosis. The most common adverse reactions by intravenous route also includes petechiae, rigors, weakness and hypokalemia.

Acute Myeloid Leukemia (AML)

Azacitidine (in combination with other antineoplastic agents) has also shown efficacy in patients with acute myeloid leukemia. A phase III clinical trial was designed to determine if more intensive induction and consolidation therapy for acute myeloblastic leukemia increases the remission rate and prolongs survival. A minor objective was to determine if the use of non-cross resistant drugs was more effective than the same drugs used for induction. Patients with untreated leukemia between the ages of 15 and 50 were given daunorubicin 45 mg/m^2 for the first 3 days of a 10-day continuous infusion of cytosine arabinoside, initially at a dose of 2000 mg/m^2 but reduced to 100 mg/m^2 because of toxicity. Those under 36 achieving a complete remission and with an histocompatible donor were assigned to a transplant arm. The rest were randomized to receive one of three consolidation arms: A, cytosine arabinoside, 200 mg/m^2 daily for 7 days and daunorubicin 45 mg/m^2 daily for 3 days for three courses; B, one course as in Arm A followed by amsacrine, 120 mg/m^2 daily for 5 days followed by a 5-day continuous infusion of azacytidine, 150 mg/m^2/day; C, thioguanine and cytosine arabinoside, 100 mg/m^2 every 12

h and daunorubicin 10 mg/m^2 daily for 5 days for three courses followed by four maintenance courses of cytosine arabinoside, 100 mg/m^2 daily for 5 days and daunorubicin, 45 mg/m^2 for 2 days every 13 weeks. From 1981 to 1986, 398 eligible patients were enrolled and 219 achieved a complete remission. The initial induction dose of cytosine arabinoside was reduced after five of 29 patients exhibited fatal gastrointestinal toxicity. Only 11 patients were assigned to the transplant arm. There were no significant differences in the consolidation arms. The 5 year disease-free survivals were 38, 31 and 27% in arms A, B, and C respectively. Intensive consolidation therapy with the same or different drugs used in induction was as effective as lower dose consolidation followed by maintenance therapy (Vogler 1995).

In a prospective controlled trial, the relative effectiveness of allogeneic bone marrow transplantation and post-remission chemotherapy was assessed for adult patients with acute myelogenous leukemia in first complete remission. Twenty-three patients, 15 to 45 years of age, who had an HLA-identical sibling donor were designated to receive bone marrow transplantation. Forty-four patients who either lacked an HLA-identical sibling or were over 45 years of age were designated to receive intensive consolidation chemotherapy. The first cycle comprised azacitidine 150 mg/m(2)/day continuous IV infusion days 1 to 5, and doxorubicin 60 mg/m(2)/day IV days 4 and 5. The second cycle was 6-TG 100 mg/m(2) orally plus Ara-C 100 mg/m(2)/day IV, both given every 12 hours days 1 to 7, in addition to DNR 60 mg/m(2)/day IV days 5 to 7 (identical to induction treatment)The actuarial rate of leukemia relapse was significantly lower in the transplantation group than in the chemotherapy group (40 +/- 25% [95% confidence interval] compared with 71 +/- 14%, p = 0.01). Actuarial survival at greater than 4 years was not significantly different (40 +/- 21% compared with 27 +/- 14%, p greater than 0.4). These data show that bone marrow transplantation is more effective than consolidation chemotherapy in preventing leukemia relapse, but overall survival was not improved in this study (Champlin 1985).

The Southeastern Cancer Study Group conducted a post-remission induction randomized trial in adult acute myelogenous leukemia to assess the efficacy of alternate drug therapy during consolidation and of immunotherapy during maintenance. Of 508 evaluable patients entered

into the study, 335 (66%) achieved a complete remission treated with a 7-day infusion of cytosine arabinoside at a dose of 100 mg/sq m/day and 3 days of daunorubicin at a dose of 45 mg/sq m/day. Those in remission were randomized to receive 3 courses of 1 of 3 consolidation regimens: (A) a continuous infusion of 5-azacytidine, 150 mg/sq m/day for 5 days; (B) 5-azacytidine plus beta-deoxythioguanosine, 300 mg/sq m/day for 5 days; or (C) cytosine arabinoside, 100 mg/sq m/day intravenously, and thioguanine, 100 mg/sq m orally every 12 hr, plus daunorubicin, 10 mg/sq m every 24 hr daily for 5 days. There was no difference in relapse rate among the 3 arms. Those completing consolidation and remaining in remission were randomized to 1 of 3 maintenance regimens: (D) chemotherapy, 5-day infusion of cytosine arabinoside and 2 days of daunorubicin (same doses as induction) given every 13 wk for 1 yr; (E) BCG given twice weekly for 1 mo and then monthly for 1 yr; or (F) the combination of regimens D and E. The median duration of remission was significantly better on regimen D (17.4 versus 9.4 and 9.5 mo), and median survival was 29 mo compared to 21 mo for the other regimens. Those given different drugs during consolidation than used for induction (regimens A and B) and subsequent chemotherapy for maintenance (regimen D) had the longest remission durations and survival. Immunotherapy was not as good as intensive chemotherapy for maintenance (Vogler 1984).

Azacitidine elicited a response to therapy in 11 patients with relapsed/refractory acute leukemias in an open-label, nonrandomized study. Patients (n=154 evaluable) having previously treated acute leukemias of various cell types were given azacitidine according to one of 5 different dosing schedules. Ninety-two percent had some form of acute nonlymphoblastic leukemia, of which 85 had acute myeloblastic leukemia (AML). The azacitidine dosing schedules were as follows: Schedule A: 750 mg/m(2) administered IV over 2 hours in 3 divided dosing on day 1 every 3 weeks; Schedule B: 300 mg/m(2)/day IV in 4 divided doses over 4 hours daily on days 1 to 5 every 3 weeks; Schedule C: 200 mg/m(2)/day IV by continuous infusion for 5 days given every 2 to 3 weeks; Schedule D: 200 mg/m(2)/day IV by continuous infusion for 7 days given every 2 to 3 weeks; Schedule E: 150 mg/m(2)/day IV by continuous infusion for 10 days given every 3 to 4 weeks. Schedule A was closed due to lack of response and B closed due to toxicity. Subsequently, Schedules C and D were developed and had

randomization of patients between them. Due to drug instability, azacitidine continuous infusions were actually 4-hour infusions administered every 6 hours with freshly mixed drug. Overall, 9 complete and 2 partial responses were noted. Of 64 patients with AML who lived beyond 14 days of trial initiation, 7 obtained complete remission. Number of responses by schedule (A through E) were 0, 1, 2, 3, and 3, respectively; differences were not statistically significant. Median duration of remission was 65 days. Thirty-four patients died within 14 days of therapy initiation. Nausea and vomiting were the most common toxicities seen and was severe in 11 Schedule C patients. Also observed were diarrhea, rash, myalgias, prolonged myelosuppression, hypotension, and central nervous system toxicity (Saiki 1981).

In a randomized, open-label study, previously treated patients receiving azacitidine for acute nonlymphocytic leukemia experienced longer remissions and survival and also more toxicity when compared with patients receiving guanazole. Twenty-four patients were randomized to azacitidine 200 mg/m(2)/day IV in 3 divided doses for 5 days or guanazole 25 g/m(2)/day IV over 24 hours for 5 days. Following treatment, bone marrow examinations were performed approximately once every 5 days. If bone marrow remained hyper-cellular, subsequent daily doses of azacitidine could be increased by 50 mg/m(2) and guanazole could be increased by 5 g/m(2). Four patients in the azacitidine group crossed over to guanazole and 2 patients in the guanazole group crossed over to azacitidine, resulting in 30 patient trials evaluated. Remission occurred in 6 of 18 patients in the azacitidine group (5 complete and 1 partial). Of those with complete remission, the median duration was 100 days and 24 days with partial remission. There was no complete remission and 1 partial remission in the guanazole group (n=12) with a median duration of 23 days. Median numbers of courses to remission were 1 and 3 for azacitidine and guanazole, respectively. The maximum response for patients receiving azacitidine was seen after 2 courses. Median survival for those assigned to azacitidine was 140 days. However, 3 of 5 patients in complete remission had also received maintenance therapy with methotrexate and had lengthened survival times. Median survival was 42 days for patients in the guanazole group. The one patient with partial remission survived for 100 days. The median duration of white blood cell nadirs were 17 days for azacitidine and 7 days for guanazole. Most common nonhematologic toxicities seen in the

azacitidine group were nausea and vomiting (severe, n=5), diarrhea (severe, n=1), fever, and neuromuscular (total, n=17; severe, n=8). Neuromuscular toxicity with azacitidine was characterized by muscle tenderness, weakness, and lethargy. In severe cases, patients could not sit up and also became irritable, confused, and somnolent. One patient became comatose following 2 consecutive administrations of azacitidine. Fever was commonly observed in patients receiving guanazole (Levi 1976).

Blastic plasmacytoid dendritic cell neoplasm (BPDCN)

Blastic plasmacytoid dendritic cell neoplasm (BPDCN) is a rare, clinically aggressive hematologic malignancy that most commonly manifests as cutaneous lesions with or without bone marrow involvement and leukemic dissemination. BPDCN can occur as an isolated disease or with other hematologic neoplasms, including myelodysplastic syndrome, chronic myeloid leukemia, chronic myelomonocytic leukemia, and acute myeloid leukemia. Two studies have shown utility of the hypomethylating agent azacitidine in BPDCN. In a case report by Laribi et al state blastic plasmacytoid dendritic cell neoplasm (BPDCN) is a rare hematologic malignancy which was first included as an independent cutaneous lymphoma in the 2008 World Health Organisation (WHO) classification (1). BPDCN usually has an extremely poor prognosis, with quick relapses after chemotherapy (2; 3). Here, the authors report two cases of patients diagnosed in 2011 with BPDCN and myelodysplasia, and who were treated for the first time with 5-azacytidine (5-Aza); a drug approved by the Food and Drug Administration (FDA) and mainly used in the treatment of myelodysplastic syndrome (Kaminskas E, et al. 2005 Clin Cancer Res, 11, 3604-8). The first case was an 81-year-old man who presented with unusual CD10+, CD56- immunohistochemistry and 45X, -Y abnormality using fluorescent in situ hybridization (FISH) analysis. The second case was a 78-year-old woman who manifested monosomy 13 and chromosome instability due to D13S319 locus deletion in 13q14 as determined by FISH. Both patients showed excellent responses of their skin lesions after one cycle of chemotherapy, and their hematological disease was stabilized; however, pulmonary sepsis set in, followed by neutropenia after the fourth and the fifth cycle of treatment, that is, eight and 9 months postdiagnosis, respectively, leading to patient death (Laribi 2014). Khwaja et al reported an additional series of 3 patients, age 75,

76, or 80 years, treated with azacitidine with or without local radiation resulting in PFS of 6, 7, and 24 months, respectively, and a median OS of 17 months. Limited toxicity was noted, which suggests that azacitidine is an appropriate therapy for patients unfit for more aggressive chemotherapy and, as often happens in our institution, serves as a bridge from relapsed disease to experimental therapy (Khawaja 2016; Sullivan 2016).

Myelodysplastic syndromes (MDS)

Azacitidine (Vidaza) is a nucleoside metabolic inhibitor indicated for the treatment of patients with the following FAB myelodysplastic syndrome (MDS) subtypes: Refractory anemia (RA) or refractory anemia with ringed sideroblasts (RARS) (if accompanied by neutropenia or thrombocytopenia or requiring transfusions), refractory anemia with excess blasts (RAEB), refractory anemia with excess blasts in transformation (RAEB-T), and chronic myelomonocytic leukemia (CMMoL).

Azacitidine (Vidaza) is a pyrimidine nucleoside analog of cytidine and is believed to exert its antineoplastic effects by causing hypomethylation of DNA and direct cytotoxicity on abnormal hematopoietic cells in the bone marrow. The concentration of azacitidine required for maximum inhibition of DNA methylation in vitro does not cause major suppression of DNA synthesis. Hypomethylation may restore normal function to genes that are critical for differentiation and proliferation. The cytotoxic effects of azacitidine cause the death of rapidly dividing cells, including cancer cells that are no longer responsive to normal growth control mechanisms. Non-proliferating cells are relatively insensitive to azacitidine.

FDA approval of Vidaza was based on a randomized, open-label, controlled trial carried out in 53 U.S. sites which enrolled a total of 191 patients (172 evaluable) with any of the five subtypes of myelodysplastic syndrome noted above. RA and RARS patients were included if they met one or more of the following criteria: required packed RBC transfusions; had platelet counts less than or equal to 50.0 x 109,/L; required platelet transfusions; or were neutropenic (ANC <1.0 x 109 /L) with infections requiring treatment with antibiotics. Patients with acute myelogenous leukemia (AML) were not intended to be included. Of the 191 patients included in the study, independent review (adjudicated diagnosis) found

that 19 had the diagnosis of AML at baseline. These patients were excluded from the primary analysis of response rate, although they were included in an intent-to-treat (ITT) analysis of all patients randomized. Supportive care allowed in this study included blood transfusion products, antibiotics, antiemetics, analgesics and antipyretics. The use of hematopoietic growth factors was prohibited. Baseline patient and disease characteristics were similar in the two groups.

Vidaza was administered at a subcutaneous dose of 75 mg/m^2 daily for 7 days every 4 weeks. The dose was increased to 100 mg/m^2 if no beneficial effect was seen after 2 treatment cycles. The dose was decreased and/or delayed based on hematologic response or evidence of renal toxicity. Patients in the observation arm were allowed by protocol to cross over to Vidaza if they had increases in bone marrow blasts, decreases in hemoglobin, increases in red cell transfusion requirements, or decreases in platelets, or if they required a platelet transfusion or developed a clinical infection requiring treatment with antibiotics. For purposes of assessing efficacy, the primary endpoint was response rate (as defined in Table 4).Subjects were randomized to receive either subcutaneous Vidaza plus supportive care (“observation”) (n=99) or supportive care alone (n=92); subjects in the supportive care arm were free to cross over to the Vidaza arm if their symptoms worsened during the trial.

The drug was seen to produce a statistically significant response in 15.7% (n=14 of 89) of evaluable subjects in the Vidaza arm, and 12.8% (n=6 of 47) of the crossover group. Of the Vidaza-arm subjects exhibiting a response, 5 of the 14 showed a complete response and 9 of the 14 showed a partial response. All patients who had been transfusion dependent became transfusion independent during partial response or complete response.

Myelodysplastic syndrome/Myeloproliferative neoplasms (MDS/MPNs)

The myelodysplastic/myeloproliferative neoplasms (MDS/MPNs) are a type of myeloid malignancies that present with both myelodysplastic and myeloproliferative phenotypic features. MDS-like features include cytopenias and dysplasia of various cell lines and MPN-like features

include constitutional symptoms (e.g. night sweats and/or weight loss), elevated blood counts as well as extramedullary infiltration. The 2008 World Health Organization (WHO) classification added the category of MDS/MPN neoplasms, which includes chronic myelomonocytic leukemia (CMML), juvenile myelomonocytic leukemia (JMML), atypical chronic myeloid leukemia (aCML), MDS/MPN unclassifiable (MDS/MPN-U), and refractory anemia with ring sideroblasts and thrombocytosis (RARS-T). Diagnosis and classification remain clinicopathologic, based on laboratory, morphological, and clinical parameters (Clara 2016, Orazi 2008, Vardiman 2009).

This review by the Italian Society of Hematology (SIE) and affiliated Societies (the Italian Society of Experimental Hematology, SIES, and the Italian Group for Bone Marrow Transplantation, GITMO) examines data regarding diagnostic criteria, evaluation needs at diagnosis, assessment of prognostic risk, and determinants of therapeutic intervention, in order to produce recommendations aimed at helping to optimize and standardize CMML clinical management. Key questions were selected according to the criterion of clinical relevance. Recommendations were produced using a Delphi process and four consensus conferences involving a panel of experts appointed by the Italian Society of Hematology and affiliated societies. This report presents the final statements and recommendations, covering patient evaluation at diagnosis, diagnostic criteria, risk classification, first-line therapy, monitoring, second-line therapy and allogeneic stem cell transplantation. For the first-line therapy, the panel recommended that patients with myelodysplastic-type chronic myelomonocytic leukemia and less than 10% blasts in bone marrow should be managed with supportive therapy aimed at correcting cytopenias. In patients with myelodysplastic-type chronic myelomonocytic leukemia with a high number of blasts in bone marrow (≥ 10%), supportive therapy should be integrated with the use of 5-azacytidine. Patients with myeloproliferative-type chronic myelomonocytic leukemia with a low number of blasts (<10%) should be treated with cytoreductive therapy. Hydroxyurea is the drug of choice to control cell proliferation and to reduce organomegaly. Patients with myeloproliferative-type chronic myelomonocytic leukemia, and a high number of blasts should receive polychemotherapy. Both in myelodysplastic-type and myeloproliferative-

type chronic myelomonocytic leukemia, allogeneic stem cell transplantation should be offered within clinical trials in selected patients (Onida 2013).

Multiple prognostic scores have been validated specifically for CMML in the past 5 years. These incorporate somatic mutations, with ASXL1 mutations repeatedly correlating with poor prognosis. Accurate prognostication can guide treatment. Hypomethylating agents (HMAs) and curative allogeneic blood or marrow transplantation (BMT) remain the most available standard treatments. Recently, a number of novel approaches using unapproved therapies (i.e., lenalidomide, ruxolitinib, sotatercept, and tipifarnib) have demonstrated some efficacy in CMML. Increased recognition and interest in CMML have led to the development of a number of new prognostic models and potential treatment options. Standard treatment options remain limited and clinical trials should be strongly considered whenever available (Elmariah 2019)

Chronic myelomonocytic leukemia (CMML) is an aggressive myeloid neoplasm in which treatment strategies with the capacity to improve survival are currently lacking. Clinical features are heterogeneous and although the overall prognosis is poor, survival can vary significantly between individuals. This reflects the need for an individualized treatment approach which incorporates accurate risk stratification. Though numerous prognostic scores exist, newer CMML-specific models incorporating molecular data should be favored. While asymptomatic, low-risk patients should be observed until their disease progresses, the majority of patients will require treatment. Due to a deficiency in treatments with disease-modifying capacity, any patient who requires treatment should be considered for enrollment in clinical trials evaluating novel therapeutic approaches. Allogeneic stem cell transplant (allo-SCT) remains the only current therapy with the potential to cure the disease and should be considered in most patients with intermediate- to high-risk disease. However, substantial risks are involved and, in part, because of advanced age at diagnosis, a minority of patients are candidates. Hypomethylating agents (HMAs) have become a preferred treatment approach, and should be used in those with cytopenias. Patients presenting with proliferative features can be treated with hydroxyurea to manage their symptoms and control leukocytosis, though HMAs can be incorporated as well, particularly in patients with higher risk disease.

HMAs should also be considered in patients with a high burden of disease prior to proceeding with allo-SCT. Induction chemotherapy should be reserved for younger, healthy patients who have transformed to acute myeloid leukemia to induce remission prior to transplant. Supportive care utilizing transfusion support, erythropoiesis-stimulating agents, and infection prevention measures should be incorporated into the care of all patients (Hunter 2018).

CPT Codes / HCPCS Codes / ICD-10 Codes

Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+":

Code	Code Description
Other CPT codes related to the CPB:	
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
96413 - 96417	Chemotherapy administration, intravenous infusion technique
HCPCS codes covered if selection criteria are met:	
J9025	Injection, azacitidine, 1 mg
Other HCPCS codes related to the CPB:	
Venetoclax - no specific code:	
ICD-10 codes covered if selection criteria are met:	
C86.4	Blastic NK-cell lymphoma
C92.00 - C92.02	Acute myeloblastic leukemia
C92.20 - C92.22	Atypical chronic myeloid leukemia, BCR/ABL - negative
C92.60 - C92.62	Acute myeloid leukemia with 11q23-abnormality
C92.A0 - C92.A2	Acute myeloid leukemia with multilineage dysplasia
C93.10 - C93.12	Chronic myelomonocytic leukemia
D46.0 - D46.9	Myelodysplastic syndromes

Code	Code Description
D47.1	Chronic myeloproliferative disease [Myeloproliferative Neoplasms (MPN) Overlap Neoplasms] [unclassifiable MDS/MPN]
D75.81	Myelofibrosis [accelerated phase or blast phase]

The above policy is based on the following references:

1. Actavis Pharma Inc. Azacitidine for injection, for subcutaneous or intraveous use. Prescribing Information. Parsippany, NJ: Actavis Pharma; revised July 2020.
2. Celgene Corporation. Vidaza (azacitidine for injection), for subcutaneous or intravenous use. Prescribing Information. Summit, NJ: Celgene Corporation; revised July 2020.
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   Hunter AM, Zhang L, Padron E. Current management and recent advances in the treatment of chronic myelomonocytic leukemia. Curr Treat Options Oncol. 2018;19(12):67. Published 2018 Oct 27.
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nonlymphocytic leukemia. Cancer 1976; 38:36-41.

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14. Vardiman JW, Thiele J, Arber DA, et al. The 2008 revision of the World Health Organization (WHO) classification of myeloid neoplasms and acute leukemia: Rationale and important changes. Blood. 2009;114:937–51.
15. Volger WR, Weiner RS, Moore JO, et al. Long-term follow-up of a randomized post-induction therapy trial in acute myelogenous leukemia (a Southeastern Cancer Study Group trial). Leukemia. 1995;9(9):1456-60.
16. Vogler WR, Winton EF, Gordon DS, Raney MR, Go B, Meyer L. A randomized comparison of post-remission therapy in acute myelogenous leukemia: A Southeastern Cancer Study Group trial. Blood. 1984;63(5):1039-45.