

*Evolent	
Clinical guidelines: HODGKIN LYMPHOMA	Original Date: June 2013
Radiation Oncology	Last Revised Date: May 2023
Guideline Number: Evolent_CG_132	Implementation Date: January 2024

GENERAL INFORMATION

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *Where a specific clinical indication is not directly addressed in this guideline, medical necessity determination will be made based on widely accepted standard of care criteria. These criteria are supported by evidence-based or peer-reviewed sources such as medical literature, societal guidelines and state/national recommendations.*

INDICATIONS FOR RADIATION THERAPY AND TREATMENT OPTIONS

2D and 3D conformal radiation therapy techniques are considered medically necessary for treatment of Hodgkin Lymphoma.¹⁻⁴

- **Combined Modality Therapy (CMT):**
 - Stage I-II (non-bulky disease): 20-30 Gy up to 20 fractions
 - Stage IB-IIB (non-bulky disease): 30 Gy up to 20 fractions
 - Stage I-IV (bulky disease): 30-36 Gy up to 24 fractions
 - Sites of Deauville 4-5 and PR to chemotherapy: 36-45 Gy up to 30 fractions
- **ISRT Alone (uncommon, except for LPHL)**
 - Involved regions: 30-36 Gy up to 24 fractions
 - Uninvolved regions: 25-30 Gy up to 20 fractions
- **Palliative:** 4-30 Gy up to 10 fractions for symptom control

TREATMENT OPTIONS TO BE REVIEWED ON A CASE-BY-CASE BASIS

Intensity Modulated Radiation Therapy (IMRT)

IMRT is not indicated as a standard treatment option and should not be used routinely for the delivery of radiation therapy for Hodgkin lymphoma. IMRT is strictly defined by the utilization of inverse planning modulation techniques. IMRT may be appropriate for limited circumstances in which radiation therapy is indicated and 3D conformal radiation therapy (3D-CRT) techniques cannot adequately deliver the radiation prescription without exceeding normal tissue radiation tolerance, the

delivery is anticipated to contribute to potential late toxicity or tumor volume dose heterogeneity is such that unacceptable hot or cold spots are created.

Clinical rationale and documentation for performing IMRT rather than 2D or 3D-CRT treatment planning and delivery will need to:

- Demonstrate how 3D-CRT isodose planning cannot produce a satisfactory treatment plan (as stated above) via the use of patient-specific dose volume histograms and isodose plans.
- Provide tissue constraints for both the target and affected critical structures.

NCCN panel recommends limiting Mean Lung Dose to < 13.5 Gy, V20 < 30%, and V5 < 55%.

Stereotactic Body Radiation Therapy⁵

Stereotactic Body Radiation Therapy (SBRT) is not currently a routine treatment option for the treatment of Hodgkin's lymphoma. SBRT may be appropriate for patients with tumors arising in or near a previously irradiated region to minimize risk to surrounding normal tissues. If requested, this would require peer to peer review to determine medical necessity.

Proton Beam Radiation Therapy

Proton beam is not an approved treatment option for Hodgkin Lymphoma. Proton beam has not been proven superior treatment to conventional radiation therapy.

THE FOLLOWING APPLIES TO CMS (MEDICARE) MEMBERS ONLY

For Proton Beam and Stereotactic Radiotherapy, refer to Local Coverage Determination (LCD), if applicable.

BACKGROUND

Due to the significant improvement in treatment for this disease, Hodgkin disease is further classified into classical Hodgkin lymphoma (that accounts for 95% of all Hodgkin cases) and lymphocyte predominant Hodgkin lymphoma. Staging for Hodgkin lymphoma is based on the Ann Arbor staging system (stage I-IV), further subdivided into "A" (no systemic symptoms presents) and "B" (weight loss of >10%, fevers, or night sweats). Unfavorable prognostic factors include bulky mediastinal disease, nodal mass >10 cm, numerous sites of disease, significantly elevated erythrocyte sedimentation rate, or B symptoms. Treatment recommendations are typically based on three subgroups of Hodgkin lymphoma: early stage favorable (stage I-II with no unfavorable factors), early stage unfavorable (stage I-II with any unfavorable factors as mentioned above), and advanced stage disease (stage III and IV). When radiation therapy is used for the treatment of Hodgkin disease, it is usually in combination with chemotherapy. If chemotherapy is used alone, radiation therapy can be used for relapse.

REFERENCES

1. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines): Hodgkin Lymphoma Version 2.2023. National Comprehensive Cancer Network (NCCN). Updated November 8, 2022. Accessed December 6, 2022. https://www.nccn.org/professionals/physician_gls/pdf/hodgkins.pdf
2. ACR Appropriateness Criteria®: Hodgkin lymphoma--favorable prognosis stage I and II. American College of Radiology. Updated 2016. Accessed December 6, 2022. <https://acsearch.acr.org/docs/69352/Narrative/>
3. ACR Appropriateness Criteria®: Hodgkin lymphoma stage III and IV. American College of Radiology. Updated 2016. Accessed December 6, 2022. <https://acsearch.acr.org/docs/69348/Narrative/>
4. Roberts KB, Younes A, Hodgson DC, et al. ACR Appropriateness Criteria(R) Hodgkin Lymphoma- Unfavorable Clinical Stage I and II. Updated Aug. Accessed December 6, 2022. <https://www.ncbi.nlm.nih.gov/pubmed/27299425>
5. American Society for Radiation Oncology. Astro Model Policies: Stereotactic Body Radiation Therapy. American Society for Radiation Oncology (ASTRO). Updated June 2020. Accessed December 6, 2022. <https://www.astro.org/ASTRO/media/ASTRO/Daily%20Practice/PDFs/ASTROSBRTModelPolicy.pdf>

POLICY HISTORY

Date	Summary
May 2023	<p>Clarified/updated radiation dose:</p> <ul style="list-style-type: none">● Combined Modality Therapy (CMT):<ul style="list-style-type: none">○ Stage I-II (non-bulky disease): 20-30Gy up to 20 fractions○ Stage IB-IIB (non-bulky disease): 30Gy up to 20 fractions○ Stage I-IV (bulky disease): 30-36Gy up to 24 fractions○ Sites of Deauville 4-5 and PR to chemotherapy: 36-45Gy up to 30 fractions● ISRT Alone (uncommon, except for LPHL)<ul style="list-style-type: none">○ Involved regions: 30-36Gy up to 24 fractions○ Uninvolved regions: 25-30Gy up to 20 fractions● Palliative: 4-30Gy up to 10 fractions for symptom control● Deleted Additional Resources● Replaced “Treatment Options Requiring Physician Review” with “Treatment Options to be reviewed on a case-by-case basis”
February 2022	Added NCCN panel recommends limiting Mean Lung Dose to < 13.5Gy, V20 <30%, and V5 <55%.

Reviewed / Approved by Clinical Guideline Committee

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