Cancer Vaccines

Number: 0557

Policy

*Please see amendment for Pennsylvania Medicaid at the end of this CPB.

Aetna considers melanoma vaccine (also known as Theraccine vaccine or Oncophage vaccine) experimental and investigational for any indication because of insufficient evidence of its safety and effectiveness.

Aetna considers helper multi-peptide (6MHP) vaccine for metastatic melanoma experimental and investigational because of insufficient evidence of its safety and effectiveness.

Aetna considers vaccine therapy including tumor-associated antigenic peptide-based vaccines in the treatment of breast cancer, central nervous system cancers (e.g., glioblastoma and neuroblastoma), colorectal cancer, head and neck cancer, lung cancer, ovarian cancer and pancreatic cancer experimental and investigational because the clinical evidence is not sufficient to permit conclusions on the health outcome effects of vaccine therapy in the treatment of these cancers.

Background
Melanoma Vaccine:

Melanoma vaccine is prepared from melanoma cell lines that are cultured in-vitro. The vaccine product is designed to contain 1 or more antigens that are unique to melanoma cells; some preparations also contain "adjuvants" (such as bacillus Calmette-Guerin [BCG]) thought to enhance immunogenicity of the preparation.

Currently, no melanoma vaccine products are licensed for marketing in the United States. Until a commercial preparation is available, there is significant potential for variability between products and batches. Effects that are seen in patients to whom these products are administered may be due to the components thought to be active, or to other components which are contaminants, adjuvants or excipients. In those studies lacking a concurrent control group, it is impossible to distinguish which components are active. Ribi Immunochem Research has developed a standardized melanoma vaccine called Melacine. As a biological, this product would be evaluated and licensed by the Center for Biological Evaluation and Research of the Food and Drug Administration (FDA). At this time, no application for licensure has been filed for this product.

Several published studies have suggested that melanoma vaccine may be effective in the treatment of malignant melanoma and/or prevention of metastasis of melanoma; however, these studies are not adequate to establish the safety and/or efficacy of this therapy. In addition, there have been a number of reports of phase I and phase II studies that have demonstrated increases in tumor-specific cytotoxic T lymphocytes and other immune responses in patients vaccinated with various melanoma vaccines. A number of these studies have incorporated interleukin-2 and other adjuvants to improve immune response to melanoma vaccine. The second interim report from a phase III, multi-center randomized controlled clinical trial of a melanoma vaccine, however, showed no significant overall survival benefit in vaccinated melanoma patients. A retrospective analysis of clinical trial results identified subsets of patients that appeared to have improved survival with the vaccine; this retrospective
analysis suggests that a vaccine may be effective in selected subgroups of melanoma patients.

Randomized controlled clinical trials, where subgroups of patients are identified prospectively, are necessary to confirm the efficacy of melanoma vaccine in selected patient subgroups. Kuhn and Hanke (1997) concluded in a recent review of the current status of melanoma vaccines that "[t]he clinical effectiveness of melanoma vaccines is unclear and adequately controlled studies need yet to be performed". A former President of the American Cancer Society stated that "[t]he success of melanoma vaccines has been inhibited by the large number of potential antigen targets on the melanoma cell, which may vary from tumor to tumor. In addition, the lack of intermediate end points for assessment of the effect of immunotherapy has impeded research in this field."

The FDA has deemed the Antigenics Inc. (New York, NY) Oncophage late-stage investigational cancer vaccine an orphan drug for metastatic melanoma. The FDA orphan drug designation was designed to encourage the development of therapies for conditions affecting fewer than 200,000 people in the United States. The designation entitles the sponsor to aid with the development program, tax breaks, waivers from certain regulatory fees and 7 years of additional marketing exclusivity if the product eventually is approved.

The Oncophage vaccine is prepared by removing a tumor from the patient and isolate specific antigens of the particular cancer. The vaccine is composed of heat-shock proteins that are bound to other proteins specific to tumor antigens. According to Antigenics, Inc., studies have shown that the protein complex, when purified from tumor cells and reintroduced to the patient, appears to stimulate cellular immunity. The immune response appears to be directed specifically to cancer cells, leaving the patient's healthy tissue intact. In May 2002, Antigenics reported that it had begun enrolling patients in the United States and Europe in a pivotal phase III trial of Oncophage for stage IV metastatic melanoma.

Elliott and Dalgleish (2004) stated that melanoma vaccines offer new hope to patients with metastatic melanoma, although convincing survival advantages have yet to be
reported. Bystryn and Reynolds (2005) stated that vaccines are a promising but still experimental treatment for melanoma.

Guidelines on malignant melanoma from the National Institute for Health and Clinical Excellence (2006) have concluded that "[v]accine therapy for advanced [malignant melanoma] remains uncertain and its use should only be in the context of a clinical trial." A systematic evidence review in BMJ Clinical Evidence (Savage, 2006) concluded that adjuvant vaccines in people with malignant melanoma are of "unknown effectiveness."

Lens and colleagues (2008) assessed different vaccines tested in stage III and/or IV melanoma patients. Systematic review of the published evidence on vaccine therapy in melanoma was carried out. Melanoma vaccines can be classified into 6 groups: (i) whole-cell vaccines, (ii) dendritic cell vaccines, (iii) peptide vaccines, (iv) ganglioside vaccines, (v) DNA vaccines and (vi) viral vectors. The main characteristics of these vaccines including their advantages and disadvantages and the results from conducted trials were presented. Clinical responses to melanoma vaccines are still poor and currently there is no melanoma vaccine with a proven efficacy. The authors concluded that vaccine therapy still remains an experimental therapy in patients with metastatic melanoma. Further research is needed although a future therapy for advanced melanoma is probably a multi-modal approach including vaccines, adjuvants and negative co-stimulatory blockade. This is in agreement with the observations of Stein and Brownell (2008) who noted that advanced melanoma has a poor prognosis, and standard adjuvant treatment offers little survival advantage. Current efforts are aimed at combining chemotherapy and novel immunomodulators, which include vaccines, cytokines, and anti-CTLA4 antibodies. Hundreds of combination therapies are currently undergoing clinical trials. All advanced melanoma patients should be considered for enrollment in a trial for their own benefit as well as for the advancement of melanoma treatment. Thus far, no single investigative approach stands out as highly effective, however, they all hold promise with rare patients showing durable responses. Most treatment protocols are evaluating combinations of adjuvant therapies, hoping to achieve a synergistic effect.
Lesterhuis and associates (2008) stated that dendritic cells are the directors of the immune system, capable of inducing tumor antigen-specific T-cell and B-cell responses. As such, they are currently applied in clinical studies in cancer patients. Early small clinical trials showed promising results, with frequent induction of anti-cancer immune reactivity and clinical responses. In recent years, additional trials have been carried out in melanoma patients, and although immunological responses are often reported, objective clinical responses remain anecdotal with objective response rates not exceeding 5 to 10%. Thus, dendritic cells vaccination research has now entered a stage in between "proof of principle" and "proof of efficacy" trials. Crucial questions to answer at this moment are why the clinical responses remain scarce and what can be done to improve the efficacy of vaccination.

Faries et al (2009) examined the effect of the addition of granulocyte/macrophage colony-stimulating factor (GM-CSF) to vaccination with a melanoma vaccine. A total of 97 patients with resected melanoma (stage II-IV) were enrolled, stratified by stage, and randomized to receive a cellular melanoma vaccine with or without GM-CSF. The primary endpoint was delayed-type hypersensitivity (DTH) response to melanoma cells. Antibody responses, peripheral leukocyte counts, and survival were also examined. The GM-CSF arm showed enhanced antibody responses with an increase in IgM titer against the TA90 antigen and increased TA90 immune complexes. This arm also had diminished anti-melanoma cell delayed-type hypersensitivity response. Peripheral blood leukocyte profiles showed increases in eosinophils and basophils with decreased monocytes in the GM-CSF arm. These immune changes were accompanied by an increase in early melanoma deaths and a trend toward worse survival with GM-CSF. The authors concluded that these findings suggested that GM-CSF is not helpful as an immune adjuvant in this dose and schedule and raised concern that it may be harmful. Based on the discordant findings of an immune endpoint and clinical outcome, the use of such surrogate endpoints in selecting treatments for further evaluation must be done with a great deal of caution.
In a phase II, multi-center, randomized trial, Slinglull et al (2009) examined whether local administration of GM-CSF augments immunogenicity of a multi-peptide vaccine. It also assessed immunogenicity of administration in 1 versus 2 vaccine sites. A total of 121 eligible patients with resected stage IIIB to IV melanoma were vaccinated with 12 major histocompatibility complex class I-restricted melanoma peptides to stimulate CD8+ T cells plus a HLA-DR-restricted tetanus helper peptide to stimulate CD4+ T cells, emulsified in incomplete Freund's adjuvant, with or without 110 microg GM-CSF. Among 119 evaluable patients, T-cell responses were assessed by IFN-gamma ELIspot assay and tetramer analysis. Clinical outcomes were recorded. CD8+ T-cell response rates to the 12 MHC class I-restricted melanoma peptides (by day 50) with or without GM-CSF were 34 % and 73 %, respectively (p < 0.001), by direct ELIspot assay. Tetramer analyses corroborated the functional data. CD4+ T-cell responses to tetanus helper peptide were higher without GM-CSF (95 % versus 77 %; p = 0.005). There was no significant difference by number of vaccine sites.

Three year overall and disease-free survival estimates (95 % confidence interval) were 76 % (67 % to 83 %) and 52 % (43 % to 61 %), respectively, with too few events to assess differences by study group. The authors concluded that high immune response rates for this multi-peptide vaccine were achieved, but CD8+ and CD4+ T-cell responses were lower when administered with GM-CSF. These data challenge the value of local GM-CSF as a vaccine adjuvant in humans.

Kaufman (2012) noted that the inherent immunogenicity of melanoma and renal cell carcinoma (RCC) has made these tumors a focus of considerable research in vaccine development. Recent data from murine studies of immunosurveillance have highlighted the importance of both innate and adaptive immune responses in shaping a tumor's inherent susceptibility to immune surveillance and immunotherapy. Melanoma has been a useful model for the identification of tumor-associated antigens and a number of putative renal cell antigens have been described more recently. These antigens have been targeted using a variety of vaccine strategies, including protein- and peptide-based vaccines, recombinant antigen-expressing vectors, and whole cell vaccine approaches. While evidence for clinical benefit has been disappointing to date, several current phase III clinical trials...
are in progress based on promising results from phase II studies. Accumulating data suggest that the tumor microenvironment and mechanisms of immunological escape by established tumors are significant barriers that must be overcome before vaccine therapy can be fully realized. The author discussed the basis for vaccine development, described some of the more promising vaccine strategies in development, and mentioned some of the tumor escape mechanisms that block effective anti-tumor immunity for melanoma and RCC. The author listed 4 phase III clinical trials in melanoma vaccine (1 completed, and 3 in progress).

**Ovarian Cancer Vaccine:**

Ovarian cancer is cancer that begins in the ovaries. In general, ovarian tumors are named according to the kind of cells the tumor started from and whether the tumor is benign or cancerous. There are 3 main types of ovarian tumors: 1) germ cell tumors start from the cells that produce the ova (eggs); 2) stromal tumors start from connective tissue cells that hold the ovary together and produce the female hormones estrogen and progesterone; 3) epithelial tumors start from the cells that cover the outer surface of the ovary.

Therapeutic vaccines are intended to coerce the cellular components of the immune system to attack malignant tissue. Prophylactic vaccines are intended to induce the production of antibodies capable of neutralizing viral antigens before they infect host cells.

The National Cancer Institute Ovarian Epithelial Cancer Treatment PDQ (2008) states that vaccines are under clinical evaluation in the treatment of ovarian cancer, primarily as part of consolidation therapy.

According to a 2010 Cochrane database review, prognosis of ovarian cancer remains poor despite advances in chemotherapy. Antigen-specific active immunotherapy aims to induce a tumor-antigen-specific anti-tumor immune responses as an alternative treatment for ovarian cancer. The objective of this study was to assess feasibility of antigen-specific active immunotherapy for ovarian cancer. A systematic search of the Cochrane Central Register of Controlled Trials (CENTRAL) Issue
3, 2009, Cochrane Gynaecological Cancer Group Specialized Register, MEDLINE and EMBASE databases and clinicaltrials.gov was performed (1966 to July 2009). Randomized controlled trials, as well as non-randomized non-controlled studies that included patients with epithelial ovarian cancer, irrespective of stage of disease, and treated with antigen-specific active immunotherapy, irrespective of type of vaccine, antigen used, adjuvant used, route of vaccination, schedule, and reported clinical or immunological outcomes. Thirty-six studies were included. Response definitions showed substantial variation between trials, which makes comparison of trial results unreliable. Information on adverse events was frequently limited. However, three large randomised placebo-controlled trials did not show any clinical benefit despite induction of immune responses in approximately 60% of patients. Other small studies targeting many different tumour antigens showed promising immunological results. As these strategies have not yet been tested in randomized controlled trials (RCTs), no reliable inferences about clinical efficacy can be made. Given the promising immunological results, limited side effects and toxicity exploration of clinical efficacy in large well-designed RCTs may be worthwhile. It was concluded that despite promising immunological responses no clinically effective antigen-specific active immunotherapy is yet available for ovarian cancer. Furthermore, the adoption of guidelines to ensure uniformity in trial conduct, response definitions and trial reporting is recommended to improve quality and comparability of immunotherapy trials.

In a review, Gardner and Jewell (2011) wrote that future trials will determine the role of biologic agents and vaccine therapies for ovarian cancer, as well as their impact on quality of life.

**Vacines for Selected Types of Cancer:**

Krishnadas et al (2013) stated that patients with relapsed stage 4 neuroblastoma have an extremely poor long-term prognosis, making the investigation of new agents of interest. These investigators reported the outcome of the first patient treated in a phase I study for relapsed neuroblastoma, using the chemotherapy agent decitabine to up-regulate cancer testis
antigen expression, followed by a dendritic cell vaccine targeting the cancer testis antigens MAGE-A1, MAGE-A3, and NY-ESO-1. The patient in this study had persistent tumor in his bone marrow after completion of standard therapy for neuroblastoma, including multi-agent chemotherapy, tumor resection, stem cell transplantation, radiation therapy, and anti-GD2 monoclonal antibodies. His marrow disease persisted despite chemotherapy, which was given while the vaccine was being produced. After 3 cycles of decitabine and vaccine, this patient achieved a complete remission and is now 1 year from his last treatment, with no evidence of tumor in his bone marrow or other sites. This patient was noted to have an increase in MAGE-A3-specific T cells. This was the first report combining demethylating chemotherapy to enhance tumor antigen expression followed by a cancer antigen vaccine.

An UpToDate review on “Treatment and prognosis of neuroblastoma” (Shohet and Nuchtern, 2014) states that “Novel therapies -- Development of new methods to treat high-risk neuroblastoma is an active area of research in pediatric oncology .... In general, novel treatments are given within a clinical trial because risks of such treatment are not fully known. Examples of therapies under investigation include immunotherapies such as anti-GD2 antibodies modified to decrease toxicities, targeted autologous T-cells, and neuroblastoma vaccines”. Furthermore, National Comprehensive Cancer Network’s clinical practice guideline on “Central nervous system cancers” (Version 1.2014) does not mention the use of vaccine as a management tool.

Hall et al (2013) discussed recent clinical trials using immunotherapy techniques to treat both non-small cell lung cancer (NSCLC) and small cell lung cancer (SCLC) and highlighted ongoing immunotherapy research efforts at the authors’ center. For NSCLC, phase II clinical trials have examined allogeneic vaccines that target either mucin 1 (MUC1), epidermal growth factor or melanoma-associated antigen 3. These vaccines are now undergoing larger phase III trials. An autologous cellular therapy directed against transforming growth factor beta-2 and a recombinant protein with antitumor properties have also shown promise in prolonging survival in NSCLC in phase II trials. The monoclonal antibodies ipilimumab, BMS-936558 (anti-PD-1), and
BMS936559 (anti-PD-L1) lead to enhanced T-cell-mediated anti-tumor effects and have produced objective responses in early-phase clinical trials. Studies for SCLC also exist, such as a novel vaccine therapy targeting p53. The authors concluded that recent clinical trials in lung cancer demonstrated the potential of immunotherapeutics to increase overall survival in patients with lung cancer compared with the current standard of care.

An UpToDate review on “Immunotherapy for non-small cell lung cancer” (Gettinger, 2014) states that “Several other vaccines are currently being evaluated in Phase III studies. Additional efforts are concentrating of developing new vaccines and combining vaccines with other immunologic agents, chemotherapy or targeted agents. Advances in DNA and RNA sequencing and drug development may also ultimately allow for the creation of personalized vaccines consisting of several antigens uniquely expressed by an individual’s tumor .... Two immunotherapeutic approaches showing promise in NSCLC are immune checkpoint inhibition and cancer vaccination.

Multiple agents are currently in advanced clinical development, and the results of ongoing randomized clinical trials will define the role of immunotherapy in the treatment of NSCLC”. Furthermore, National Comprehensive Cancer Network’s clinical practice guideline on “Non-small cell lung cancer” (Version 3.2014) does not mention the use of vaccine as a management tool.

In a phase II clinical trial, Morse et al (2013) examined if 1 of 2 vaccines based on dendritic cells (DCs) and poxvectors encoding CEA (carcinoembryonic antigen) and MUC1 (PANVAC) would lengthen survival in patients with resected metastases of colorectal cancer (CRC). Patients, disease-free after CRC metastasectomy and peri-operative chemotherapy (n = 74), were randomized to injections of autologous DCs modified with PANVAC (DC/PANVAC) or PANVAC with per injection GM-CSF (granulocyte-macrophage colony-stimulating factor). End-points were recurrence-free survival, overall survival (OS), and rate of CEA-specific immune responses. Clinical outcome was compared with that of an unvaccinated, contemporary group of patients who had undergone CRC metastasectomy,
received similar peri-operative therapy, and would have otherwise been eligible for the study. Recurrence-free survival at 2 years was similar (47% and 55% for DC/PANVAC and PANVAC/GM-CSF, respectively) ($\chi^2 P = 0.48$). At a median followup of 35.7 months, there were 2 of 37 deaths in the DC/PANVAC arm and 5 of 37 deaths in the PANVAC/GM-CSF arm. The rate and magnitude of T-cell responses against CEA was statistically similar between study arms. As a group, vaccinated patients had superior survival compared with the contemporary unvaccinated group. The authors concluded that both DC and poxvector vaccines had similar activity. Survival was longer for vaccinated patients than for a contemporary unvaccinated group, suggesting that a RCT of poxvector vaccinations compared with standard follow-up after metastasectomy is warranted.

Ding and Ming (2014) noted that lung cancer is the most common malignancy worldwide in terms of incidence and mortality. The vast majority of cases (85 to 90%) are NSCLC. Immunotherapy consists of mainly therapeutic vaccination designed to induce or amplify the immune responses directed against tumor-associated antigens. However, there is no conclusion to date for its strengths and weaknesses. Assessing the objective safety and effectiveness of the therapeutic vaccination for NSCLC patients will help to figure out the future development of therapeutic vaccination. These investigators performed a meta-analysis of 6 RCTs including 2,239 patients (1,363 patients in the therapeutic vaccination group and 876 patients in the control group) with NSCLC. Quantitative analysis was carried out to evaluate OS and toxicity of therapeutic vaccination. The vaccine group had produced significant improvement in OS compared with the control group (hazard ratio [HR] 0.83, 95% confidence interval [CI]: 0.76 to 0.91; $Z = 3.79$, $p = 0.0002$). Subgroup analysis showed a more significant improvement of OS in the subgroup compared with the control group (HR 0.70, 95% CI: 0.59 to 0.82; $Z = 4.42$, $p < 0.00001$).

No increased incidence of adverse events was obtained in the therapeutic vaccination group compared with the control group. The authors concluded that therapeutic vaccination added benefits to NSCLC patients and may become a standard complementary therapeutic approach in the future if the associated toxicity is reduced.
Wang et al (2014) stated that glioblastoma multiforme (GBM) has a poor prognosis. In a systematic review and meta-analysis, these investigators analyzed the outcomes of clinical trials that compared immunotherapy with conventional therapy for the treatment of malignant gliomas. PubMed, Cochrane and Google Scholar databases were searched for relevant studies.

The 2-year survival rate was used to evaluate effectiveness of immunotherapy. Of 171 studies identified, 6 comparative trials were included in the systematic review. Immunotherapy was associated with a significantly longer OS and 2-year survival compared to conventional therapy. The authors concluded that immunotherapy may improve the survival of patients with GBM.

Kobayashi et al (2014) stated that DC-based cancer vaccines may have a significant benefit to patients with advanced pancreatic cancer. However, variations among clinical studies make it difficult to compare clinical outcomes. These investigators identified factors that determined the clinical benefits by analyzing data obtained at 7 Japanese institutions that employed the same DC preparation and treatment regimens. Of 354 patients who met the inclusion criteria, 255 patients who received standard chemotherapy combined with peptide-pulsed DC vaccines were analyzed. The mean survival time from diagnosis was 16.5 months (95 % CI: 14.4 to 18.5) and that from the first vaccination was 9.9 months (95 % CI: 8.0 to 12.9). Known prognostic baseline factors related to advanced pancreatic cancer, namely ECOG-PS, peritoneal metastasis, liver metastasis, and the prognostic nutrition index, were also representative. Importantly, these researchers found that erythema reaction after vaccination was an independent and treatment-related prognostic factor for better survival and that OK-432 might be a good adjuvant enhancing the antitumor immunity during DC vaccination. The authors concluded that this was the first report of a multi-center clinical study suggesting the feasibility and possible clinical benefit of an add-on DC vaccine in patients with advanced pancreatic cancer who are undergoing chemotherapy. They stated that these findings need to be addressed in well-controlled, prospective randomized trials.
Helper Multi-Peptide (6MHP) Vaccine for Metastatic Melanoma:

Hu and colleagues (2015) stated that a multi-peptide vaccine (6MHP), designed to induce helper T cells against melanocytic and cancer-testis antigens, has been shown to induce specific Th1-dominant CD4+ T cell responses. These researchers compared the long-term outcome of patients with metastatic melanoma vaccinated with 6MHP to that of a group of unvaccinated historical controls. The 6MHP vaccine was given to patients with metastatic melanoma. Circulating CD4+ T cell responses were measured by proliferation or direct IFN-gamma ELIspot assay. Overall survival of vaccinated patients was compared to a group of clinically comparable historical controls using multi-variable Cox regression analysis and Kaplan-Meier survival analysis, taking into account age, metastatic site, and resection status. Across 40 vaccinated patients and 87 controls, resection status (HR 0.54, p = 0.004) and vaccination (HR 0.24, p < 0.001) were associated with improved OS. Forty pairs of vaccinated patients and controls were matched by metastatic site, resection status, and age within 10 years. Median survival was significantly longer for vaccinated patients (5.4 versus 1.3 years, p < 0.001). Among the vaccinated patients, the development of a specific immune response after vaccination was associated with improved survival (HR 0.35, p = 0.040). The authors concluded that helper peptide vaccination was associated with improved OS among patients with metastatic melanoma; they stated that these data support a randomized prospective trial of the 6MHP vaccine.

Tumor-Associated Antigenic Peptide-Based Vaccines for Cancers:

Peres Lde and associates (2015) discussed peptide-based vaccines in breast cancer, immune responses and clinical outcomes, which include studies on animal models and phase I, phase I/II, phase II and phase III clinical trials. These researchers stated that peptide-based vaccines are powerful neoadjuvant immunotherapies that can directly target proteins expressed in tumor cells, mainly tumor-associated antigens (TAAs). The most common breast cancer TAAs are derived from MUC1, HER2/neu and CEA proteins. Peptides derived from TAAs could be successfully used to
elicit CD8 and CD4 T cell-specific responses. Thus, choosing peptides that adapt to natural variations of human leukocyte antigen (HLA) genes is critical. The most attractive advantage is that the target response is more specific and less toxic than for other therapies and vaccines. Prominent studies on NeuVax-E75 (epitope for HER2/neu and GM-CSF) in breast cancer and DPX-0907 (HLAA2-TAAs) expressed in breast cancer, ovarian and prostate cancer have shown the efficacy of peptide-based vaccines as neoadjuvant immunotherapy against cancer. The authors concluded that future peptide vaccine strategies, although a challenge to be applied in a broad range of breast cancers, point to the development of degenerate multi-epitope immunogens against multiple targets.

Nishimura and co-workers (2015) noted that recent genomewide cDNA microarray analysis of gene expression profiles in comprehensive tumor types coupled with isolation of cancer tissues by laser-microbeam microdissection have revealed ideal TAAs that are frequently over-expressed in various cancers including head and neck squamous cell cancer (HNSCC) and lung cancer, but not in most normal tissues except for testis, placenta, and fetal organs. Pre-clinical studies using HLA transgenic mice and human T cells in-vitro showed that TA A-derived CTL-epitope short peptides (SPs) are highly immunogenic and induce HLA-A2 or -A24-restricted CTLs. Based on the accumulated evidence, these researchers carried out a phase II clinical trial of the TA A-SP vaccine in advanced 37 HNSCC patients. This study showed a significant induction of TA A-specific CTLs in the majority of patients without serious adverse effects. Importantly, clinical responses including a complete response were observed in this study. Another phase II clinical trial of therapeutic TA A-SP vaccine, designed to evaluate the ability of prevention of recurrence, is ongoing in HNSCC patients who have received curative operations. Further studies in human pre-clinical studies and in-vivo studies using HLA class I transgenic mice showed TA A-derived long peptides (TAA-LPs) have the capacity to induce not only promiscuous HLA class II-restricted CD4(+) T helper type 1 cells but also tumor-specific CTLs through a cross-presentation mechanism. Moreover, these investigators observed an augmentation of TA A-LP-specific T helper type 1 cell responses and tumor antigen-spreading in HNSCC patients vaccinated with TA A-
SPs. The authors concluded that this accumulated evidence suggested that therapeutic TA A-SPs and LPs vaccines may provide a promising cancer immunotherapy.

### 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 "+".

ICD-10 codes will become effective as of October 1, 2015:

There is no specific CPT code for melanoma vaccine (e.g., Theraccine vaccine or Oncophage vaccine) or cancer vaccine therapy.

ICD-10 codes not covered for indications listed in the CPB:

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<th>Code</th>
<th>Description</th>
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<tr>
<td>C18.0</td>
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<td>C21.8</td>
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<td>C25.0</td>
<td>Malignant neoplasm of pancreas</td>
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<tr>
<td>C34.00</td>
<td>Malignant neoplasm of bronchus and lung</td>
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<tr>
<td>Z23</td>
<td>Encounter for immunization</td>
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</tbody>
</table>
The above policy is based on the following references:

**Melanoma Vaccine**


42. Weston A, Standfield L, Hillman A. M-VAX(TM) - a treatment for patients with advanced stage III melanoma. MSAC Application 1049. Canberra, ACT: Medical Services Advisory Committee (MSAC); 2002.


44. Lawson DH. Update on the systemic treatment of malignant melanoma. Semin Oncol. 2004;31(2 Suppl


48. Sondak VK, Sabel MS, Mule JJ. et al. Allogeneic and autologous melanoma vaccines: Where have we been and where are we going? Clin Cancer Res. 2006;12(7 Pt 2):2337s-2341s.


Ovarian Cancer Vaccine


15. U.S. Food and Drug Administration.


Vaccines for Selected Types of Cancer:


3. Shohet JM, Nuchtern JG. Treatment and prognosis of neuroblastoma. UpToDate Inc., Waltham, MA. Last reviewed April 2014.

4. Gettinger S. Immunotherapy for non-small cell lung
cancer. UpToDate Inc., Waltham, MA. Last reviewed April 2014.


antigenic peptides identified by genome-wide cDNA microarray analyses. Cancer Sci. 2015;106(5):505-511


AETNA BETTER HEALTH® OF PENNSYLVANIA

Amendment to
Aetna Clinical Policy Bulletin Number: 0557
Cancer Vaccines

There are no amendments for Medicaid.

www.aetnabetterhealth.com/pennsylvania