THERAKOS® Photopheresis
2020 Coding and Reimbursement
Reference

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You are ultimately responsible for determining the appropriate reimbursement strategies and billing codes.
Hospital Reimbursement

Outpatient Payment

Medicare assigns extracorporeal photopheresis (CPT 36522) to Ambulatory Payment Classification (APC) 5243.

The 2020 U.S. unadjusted Medicare payment rate is $3,817.93** (actual payment rate varies by geographic locality)

Commercial insurer payment is generally based on either:

- A flat, comprehensive rate per treatment session based on the CPT or APC, or
- A fixed percentage of the hospital’s submitted charges

Outpatient (OPPS) Payment for Extracorporeal Photopheresis (Medicare)

| CPT 36522 | Medicare Intermediary: Assigns to APC 5243 | Relative weight 47.261 | Dollar conversion factor (2020) - $80.78 | 2020 Payment Rate = $3817.93 |

*This is the Medicare national average. Payment will vary by region.*

Secure insurance pre-authorization whenever possible before initiating therapy.

Inpatient Payment

Medicare payment for THERAKOS Photopheresis is subsumed under one of several Medicare Severity-Adjusted Diagnosis Related Groups (MS-DRGs) with a predetermined payment rate.

- The MS-DRG is dictated by (1) the cutaneous T-cell lymphoma (CTCL) diagnosis code (or other principal diagnosis code) and (2) the presence or absence of complications or comorbidities (CCs) or major complications and comorbidities (MCCs)
- Your hospital’s actual payment rate under the assigned MS-DRG is influenced by a number of variables, including your area wage index, medical residency teaching activity and volume of care to low-income patients

Commercial insurers most commonly pay for inpatient THERAKOS® Photopheresis on the basis of a percentage of charges, included in a DRG rate, or included in a per diem rate.

You are ultimately responsible for determining the appropriate reimbursement strategies and billing codes.

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Applicable fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

** Per 2020 CMS Final Rule
Physician Billing for Professional Services

Physician Payment Rate (Hospital or “Facility Fee”)

**THERAKOS® Photopheresis**
CPT Code 36522

- **Medicare:** 2.82 RVUs
- **Dollar conversion factor per RVU:**
- **Payment rate**

*After relative value unit (RVU) conversion, rate is adjusted to reflect local practice costs.*

**Commercial Carrier:**
UCR* or negotiated fee schedule

- **2020 conversion factor = $36.09 (Rounded)**
- **2020 Physician Fee (National Average) = $101.77**

* Usual, Customary and Reasonable fees

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Physician Payment Rate (Non-Facility Setting)

**THERAKOS® Photopheresis**
CPT Code 36522

- **Medicare:** 54.6 RVUs
- **Dollar conversion factor per RVU:**
- **Payment rate**

*After relative value unit (RVU) conversion, rate is adjusted to reflect local practice costs.*

**Commercial Carrier:**
UCR* or negotiated fee schedule

- **2020 conversion factor = $36.09 (Rounded)**
- **2020 Physician Fee (National Average) = $1,970.49**

* Usual, Customary and Reasonable fees

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Composition of RVUs

<table>
<thead>
<tr>
<th>CPT</th>
<th>CPT Description</th>
<th>Work RVUs</th>
<th>Non-Facility Practice Expense RVUs</th>
<th>Facility Practice Expense</th>
<th>Mal-Practice RVUs</th>
<th>Total Non-Facility RVUs</th>
<th>Total Facility RVUs</th>
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</thead>
<tbody>
<tr>
<td>36522</td>
<td>Photopheresis A</td>
<td>1.75</td>
<td>52.74 A</td>
<td>0.96 C</td>
<td>0.11 D</td>
<td>54.60 A+B+D</td>
<td>2.82 A+C+D</td>
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</tbody>
</table>
Mycosis fungoides and Sézary syndrome (forms of CTCL) are classified under *Malignant Neoplasms of Lymphatic and Hematopoietic Tissue* in the ICD-10-CM coding system. A fifth-digit subclassification may be applied to the ICD-10-CM codes if supporting documentation is available from the patient’s chart.

### Mycosis Fungoides

<table>
<thead>
<tr>
<th>ICD-10 code</th>
<th>FIFTH-DIGIT SUBCLASSIFICATIONS</th>
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<tbody>
<tr>
<td>C84.0</td>
<td>0 Unspecified site</td>
</tr>
<tr>
<td></td>
<td>1 Lymph nodes of head, face and neck</td>
</tr>
<tr>
<td></td>
<td>2 Intrathoracic lymph nodes</td>
</tr>
<tr>
<td></td>
<td>3 Intra-abdominal lymph nodes</td>
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<tr>
<td></td>
<td>4 Lymph nodes of axilla upper limb</td>
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</table>

### Sézary Syndrome

<table>
<thead>
<tr>
<th>ICD-10 code</th>
<th>FIFTH-DIGIT SUBCLASSIFICATIONS</th>
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<tbody>
<tr>
<td>C84.1</td>
<td>5 Lymph nodes of inguinal region and lower limb</td>
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<tr>
<td></td>
<td>6 Intrapelvic lymph nodes</td>
</tr>
<tr>
<td></td>
<td>7 Spleen</td>
</tr>
<tr>
<td></td>
<td>8 Lymph nodes of multiple sites</td>
</tr>
<tr>
<td></td>
<td>9 Extranodal and solid organ sites</td>
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</table>

Example: C84.18 represents Sézary syndrome with lymph node involvement in multiple sites.

### Procedure Codes

<table>
<thead>
<tr>
<th>PROCEDURE CODE DESCRIPTOR</th>
<th>CODE</th>
<th>TYPE OF CODE</th>
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<tbody>
<tr>
<td>Extracorporeal photopheresis</td>
<td>36522</td>
<td>CPT-4 procedure code</td>
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<tr>
<td>Phototherapy, Circulatory, Single</td>
<td>6A650ZZ</td>
<td>ICD-10 procedure code</td>
</tr>
<tr>
<td>Phototherapy, Circulatory, Multiple</td>
<td>6A651ZZ</td>
<td>ICD-10 procedure code</td>
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</table>


The THERAKOS® CELLEX® Photopheresis Systems are not designed, sold or intended for use in any manner other than as described in the FDA approved indication.

**You are ultimately responsible for determining the appropriate reimbursement strategies and billing codes.**
UVADEX®
(Methoxsalen)
STERILE SOLUTION, 20 mcg/mL
Rx ONLY.

CAUTION: READ THE THERAKOS® UVAR XTS® or THERAKOS® CELLEX® PHOTOPHERESIS SYSTEM OPERATOR’S MANUAL PRIOR TO PRESCRIBING OR DISPENSING THIS MEDICATION.

UVADEX® (methoxsalen) Sterile Solution should be used only by physicians who have special competence in the diagnosis and treatment of cutaneous T-cell lymphoma and who have special training and experience in the THERAKOS® UVAR XTS® or THERAKOS® CELLEX® Photopheresis System. Please consult the appropriate Operator’s Manual before using this product.

DESCRIPTION
Methoxsalen is a naturally occurring photoactive substance found in the seeds of the Ammi majus (Umbelliferae) plant. It belongs to a group of compounds known as psoralens or furocoumarins. The chemical name of methoxsalen is 9-methoxy-7H-furo[3,2-g][1]-benzopyran-7-one; it has the following structure:

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          0-CH3
         /       \
        /         \
       /           \
      /             \
     /               \
    /                 \
   /                   \
  /                     \
 /                       \

UVADEX® (methoxsalen, 8-methoxypsoralen)
Sterile Solution contains methoxsalen 20 mcg, propylene glycol 50 mg, sodium chloride 8 mg, sodium acetate 1.75 mg, ethanol 40.550 mg, glacial acetic acid 1.260 mg, and Water for Injection q.s. to 1.0 mL. Glacial acetic acid and sodium hydroxide are used to adjust the pH of the solution if necessary. UVADEX® is a clear, colorless to pale yellow liquid.

UVADEX® is used in combination with the THERAKOS® UVAR XTS® and THERAKOS® CELLEX® Photopheresis Systems to extracorporeally treat leukocyte enriched buffy coat.

CLINICAL PHARMACOLOGY
Mechanism of action: The exact mechanism of action of methoxsalen is not known. The best-known biochemical reaction of methoxsalen is with DNA. Methoxsalen, upon photoactivation, conjugates and forms covalent bonds with DNA which leads to the formation of both monofunctional (addition to a single strand of DNA) and bifunctional adducts (crosslinking of psoralen to both strands of DNA). Reactions with proteins have also been described. The formation of photoadducts results in inhibition of DNA synthesis, cell division and epidermal turnover.

For the palliative treatment of Cutaneous T-Cell Lymphoma, Photopheresis consists of removing a portion of the patient’s blood and separating the red blood cells from the white cell layer (buffy coat) by centrifugation. The red cells are returned to the patient and the UVADEX® Sterile Solution is then injected into the instrument and mixed with the buffy coat. The instrument then irradiates this drug-cell mixture with ultraviolet light (UVA light, 320–400 nm) and returns the treated cells to the patient. See the appropriate Operator’s Manual for details of this process. Although extracorporeal phototherapy exposes less than 10% of the total body burden of malignant cells to methoxsalen plus light, some patients achieve a complete response. Animal studies suggest that the photopheresis may activate an immune-mediated response against the malignant T-cells.

Use of the UVAR and UVAR XTS® Systems after oral administration of methoxsalen were previously approved for the treatment of Cutaneous T-Cell Lymphoma. Interpatient variability in peak plasma concentration after an oral dose of methoxsalen ranges from 6 to 15 fold. UVADEX® is injected directly into the separated buffy coat in the instrument in an attempt to diminish this interpatient variability and to improve the exposure of the cells to the drug.

Methoxsalen is reversibly bound to serum albumin and is also preferentially taken up by epidermal cells. Methoxsalen is rapidly metabolized in humans, with approximately 95% of the drug excreted as metabolites in the urine within 24 hours.

Systemic administration of methoxsalen followed by UVA exposure leads to cell injury. The most obvious manifestation of this injury after skin exposure is delayed erythema, which may not begin for several hours and peaks at 48–72 hours. The inflammation is followed over several days to weeks, by repair which is manifested by increased melanization of the epidermis and thickening of the stratum corneum.

Each mL of UVADEX® (methoxsalen, 8-methoxypsoralen) Sterile Solution contains methoxsalen 20 mcg, propylene glycol 50 mg, sodium chloride 8 mg, sodium acetate 1.75 mg, ethanol 40.550 mg, glacial acetic acid 1.260 mg, and Water for Injection q.s. to 1.0 mL. Glacial acetic acid and sodium hydroxide are used to adjust the pH of the solution if necessary. UVADEX® is a clear, colorless to pale yellow liquid.
The total dose of methoxsalen delivered in UVADEX® is substantially lower (approximately 200 times) than that used with oral administration. More than 80% of blood samples collected 30 minutes after reinfusion of the photoactivated buffy coat had methoxsalen levels below detection limits of the assay (<10 ng/ml), and the mean plasma methoxsalen concentration was approximately 25 ng/ml.

**CLINICAL STUDIES**

Three single-arm studies were performed to evaluate the effectiveness of photopheresis in the treatment of the skin manifestations of Cutaneous T-Cell Lymphoma (CTCL). In the first study (CTCL 1), 39 patients were treated with the oral formulation of methoxsalen in conjunction with the UVAR Photopheresis System. The second study (CTCL 2) was a 5-year post approval follow-up of 57 CTCL patients that was conducted to evaluate long-term safety. This study also used the oral dosage formulation of methoxsalen. In the third study (CTCL 3), 51 patients were treated with the UVADEX® formulation of methoxsalen in conjunction with the UVAR Photopheresis System. In study CTCL 3, 86% of the patients were Caucasian, the median age was 62 years, and the average number of prior therapies was 4.3.

In study CTCL 1, prednisone up to 10 mg/day was permitted in addition to topical steroids. In CTCL 2, there was no concomitant medication restriction. In CTCL 3, topical steroids were permitted only for the treatment of fissures on the soles of the feet and the palms of hands. All other steroids, topical or systemic, were prohibited.

In all three studies, patients were initially treated on two consecutive days every four to five weeks. If the patient did not respond after four cycles, treatment was accelerated to two consecutive days every other week. If the patient did not respond after four cycles at the accelerated schedule, the patient was treated on two consecutive days every week. If the patient still did not respond after four cycles of weekly treatments, the schedule was increased to three consecutive days every week for three cycles. In study CTCL 3, 15 of the 17 responses were seen within six months of treatment. Only two patients responded to treatment after six months. Clinical experience does not extend beyond this treatment frequency and there is no evidence to show that treatment with UVADEX® beyond six months or using a different schedule provided additional benefit.

Overall skin scores were used in the clinical studies of photopheresis to assess the patient’s response to treatment. The patient’s baseline skin score was used for comparison with subsequent scores. A 25% reduction in skin score maintained for four consecutive weeks was considered a successful response to photopheresis therapy. Table 1 indicates the percent of successful responses within six months of beginning therapy for all patients who received at least one course of photopheresis. Only patients with patch plaque, extensive plaque and erythrodermic disease were enrolled in these studies. No patients with disease in the tumor phase were treated. There are no data available regarding the efficacy of UVADEX® in patients with disease in the tumor phase.

**Table 1: Percentage of Successful Responses Within Six Months of Beginning Therapy**

<table>
<thead>
<tr>
<th>Study</th>
<th>Response % Within Six Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTCL 3 (UVADEX®)</td>
<td>17/51 (33)</td>
</tr>
<tr>
<td>CTCL 2 (oral methoxsalen)</td>
<td>16/57 (28)</td>
</tr>
<tr>
<td>CTCL 1 (oral methoxsalen)</td>
<td>21/39 (54)</td>
</tr>
</tbody>
</table>

Although the response rate with UVADEX® in CTCL 3 was similar to with oral methoxsalen in CTCL 2, the possibility that UVADEX® is inferior in efficacy to oral methoxsalen cannot be excluded due to the design and size of the clinical trials. The higher response rate with oral methoxsalen in CTCL 1 may be partly due to patients receiving more treatments (mean of 64 in CTCL 1, 31 in CTCL 2, and 20 in CTCL 3), and to the administration of systemic steroids in CTCL 1.

Retrospective analyses of three clinical benefit parameters from the Body Area Severity Scores in CTCL 3 suggested a correlation between skin score response and improvement in edema, scaling and resolution of fissures.

**INDICATIONS AND USAGE**

UVADEX® (methoxsalen) Sterile Solution is indicated for extracorporeal administration with the THERAKOS® UVAR XTS® or THERAKOS® CELLEX® Photopheresis System in the palliative treatment of the skin manifestations of Cutaneous T-Cell Lymphoma (CTCL) that is unresponsive to other forms of treatment.

**CONTRAINDICATIONS**

PHOTOSENSITIVITY: UVADEX® (methoxsalen) Sterile Solution is contraindicated in patients exhibiting idiosyncratic or hypersensitivity reactions to methoxsalen, other psoralen compounds or any of the excipients. Patients possessing a specific history of a light sensitive disease state should not initiate methoxsalen therapy. Diseases associated with photosensitivity include lupus erythematosus, porphyria cutanea tarda, erythropoietic protoporphyria, variegate porphyria, xeroderma pigmentosum and albinism.

UVADEX® Sterile Solution is contraindicated in patients with aphakia, because of the significantly increased risk of retinal damage due to the absence of lenses. Patients should not receive UVADEX® if they have any contraindications to the photopheresis procedure.
WARNINGS

Concomitant Therapy: Patients who are receiving concomitant therapy (either topically or systemically) with known photosensitizing agents such as anthralin, coal tar or coal tar derivatives, griseofulvin, phenothiazines, nalidixic acid, halogenated salicylanilides (bacteriostatic soaps), sulfonamides, tetracyclines, thiazides, and certain organic staining dyes such as methylene blue, toluidine blue, rose bengal and methyl orange may be at greater risk for photosensitivity reactions with UVADEX®.

Carcinogenicity, Mutagenesis, Impairment of Fertility: Oral administration of methoxsalen followed by cutaneous UVA exposure (PUVA therapy) is carcinogenic. In a prospective study of 1380 patients given PUVA therapy for psoriasis, 237 patients developed 1422 cutaneous squamous cell cancers. This observed incidence of cutaneous carcinoma is 17.6 times that expected for the general population. Previous cutaneous exposure to tar and UVB treatment, ionizing radiation or arsenic increased the risk of developing skin carcinomas after PUVA therapy. Because the dose of methoxsalen with UVADEX® therapy is about 200 times less than with PUVA and the skin is not exposed to high cumulative doses of UVA light, the risk of developing skin cancer following UVADEX® therapy may be lower.

Methoxsalen was carcinogenic in male rats that were given the drug by oral gavage five days per week for 103 weeks at doses of 37.5 and 75 mg/kg. The 37.5 mg/kg dose is about 1900 times greater than a single human methoxsalen dose during extracorporeal photopheresis treatment on a body surface area basis. The neoplastic lesions in rats included adenomas and adenocarcinomas of the tubular epithelium of the kidneys, carcinoma or squamous cell carcinoma of the Zymbal gland and alveolar or bronchiolar adenomas. Topical or intraperitoneal methoxsalen is a potent photo-carcinogen in albino mice and hairless mice.

With S9 activation, methoxsalen is mutagenic in the Ames test. In the absence of S9 activation and UV light, methoxsalen is clastogenic in vitro (sister chromatid exchange and chromosome aberrations in Chinese hamster ovary cells). Methoxsalen also causes DNA damage, interstrand cross-links and errors in DNA repair.

Pregnancy: Methoxsalen may cause fetal harm when given to a pregnant woman. Doses of 80 to 160 mg/kg/day given during organogenesis caused significant fetal toxicity in rats. The lowest of these doses, 80 mg/kg/day, is over 4000 times greater than a single dose of UVADEX® on a mg/m² basis. Fetal toxicity was associated with significant maternal weight loss, anorexia and increased relative liver weight. Signs of fetal toxicity included increased fetal mortality, increased resorptions, late fetal death, fewer fetuses per litter, and decreased fetal weight. Methoxsalen caused an increase in skeletal malformation and variations at doses of 80 mg/kg/day and above. There are no adequate and well-controlled studies of methoxsalen in pregnant women. If UVADEX® is used during pregnancy, or if the patient becomes pregnant while receiving UVADEX®, the patient should be apprised of the potential hazard to the fetus. Women of childbearing potential should be advised to avoid becoming pregnant.

PRECAUTIONS

General: ACTINIC DEGENERATION:
After methoxsalen administration, exposure to sunlight and/or ultraviolet radiation may result in “premature aging” of the skin.

BASAL CELL CARCINOMAS:
Since oral psoralens may increase the risk of skin cancers, monitor closely those patients who exhibit multiple basal cell carcinomas or who have a history of basal cell carcinomas.

SERIOUS SKIN BURNS:
Serious burns from either UVA or sunlight (even through window glass) can result if the recommended dosage of methoxsalen is exceeded or precautions are not followed. Advise patients to avoid all exposure to sunlight during the 24 hours following photopheresis treatment.

CATARACT FORMATION:
Exposure to large doses of UVA light causes cataracts in animals. Oral methoxsalen exacerbates this toxicity. The concentration of methoxsalen in the human lens is proportional to the concentration in serum. Serum methoxsalen concentrations are substantially lower after extracorporeal UVADEX® treatment than after oral methoxsalen treatment. Nevertheless, if the lens is exposed to UVA light while methoxsalen is present, photoactivation of the drug may cause adducts to bind to biomolecules within the lens. If the lens is shielded from UVA light, the methoxsalen will diffuse out of the lens in about 24 hours.

Patients who use proper eye protection after PUVA therapy (oral methoxsalen) appear to have no increased risk of developing cataracts. The incidence of cataracts in these patients five years after their first treatment is about the same as that in the general population.

Instruct patients emphatically to wear UVA absorbing, wrap-around sunglasses for twenty-four (24) hours after UVADEX® treatment. They should wear these glasses any time they are exposed to direct or indirect sunlight, whether they are outdoors or exposed through a window.

VENOUS AND ARTERIAL THROMBOEMBOLISM:
Thromboembolic events, such as pulmonary embolism and deep vein thrombosis, have been reported with UVADEX administration through photopheresis systems for treatment of patients with graft-versus-host disease, a disease for which UVADEX is not approved.
**ADVERSE REACTIONS**

Side effects of photopheresis (UVADEX® used with the THERAKOS® Photopheresis System) were primarily related to hypotension secondary to changes in extracorporeal volume (>1%). In study CTCL 3 (UVADEX®), six serious cardiovascular adverse experiences were reported in five patients (5/51, 10%). Five of these six events were not related to photopheresis and did not interfere with the scheduled photopheresis treatments. One patient (1/51, 2%) with ischemic heart disease had an arrhythmia after the first day of photopheresis that was resolved the next day. Six infections were also reported in five patients. Two of the six events were Hickman catheter infections in one patient, which did not interrupt the scheduled photopheresis. The other four infections were not related to photopheresis and did not interfere with scheduled treatments.

**POSTMARKETING:** An analysis of postmarketing data shows the following events occurred with an incidence of <0.01%: rash, allergic reaction, pyrexia, nausea, dysgeusia.

**OVERdosage**

There are no known reports of overdosage with extracorporeal administration of methoxsalen. However, in the event of overdosage, the patient should be kept in a darkened room for at least 24 hours.

**DRUG DOSAGE AND ADMINISTRATION**

Each UVADEX® treatment involves collection of leukocytes, photoactivation, and reinfusion of photoactivated cells. UVADEX® (methoxsalen) Sterile Solution is supplied in 10 mL vials containing 200 mcg of methoxsalen (concentration of 20 mcg/mL). The THERAKOS® UVAR XTS® or THERAKOS® CELLEX® Photopheresis System Operator’s Manual should be consulted before using this product. UVADEX® should not be diluted. The contents of the vial should be injected into the THERAKOS® UVAR XTS® or THERAKOS® CELLEX® Photopheresis System immediately after being drawn up into a syringe. Do not inject directly into patients. The UVADEX® vial is for single use only. Any UVADEX® that is not used during a procedure should be immediately discarded. UVADEX® can adsorb onto PVC and plastics, therefore only THERAKOS® UVAR XTS® or THERAKOS® CELLEX® photopheresis procedural kits supplied for use with the instrument should be used to administer this medicinal product. Once UVADEX® is drawn into a plastic syringe it should be immediately injected into the photoactivation bag. UVADEX® exposed to a plastic syringe for more than one hour should be discarded.

During treatment with the THERAKOS® UVAR XTS® or THERAKOS® CELLEX® Photopheresis System, the dosage of UVADEX® for each treatment will be calculated according to the treatment volume.

- The prescribed amount of UVADEX® should be injected into the recirculation bag prior to the Photoactivation Phase using the formula:

  \[
  \text{TREATMENT VOLUME} \times 0.017 = \text{mL of UVADEX® for each treatment}
  \]

  Example: Treatment volume of 240 mL \( \times 0.017 = 4.1 \text{ mL of UVADEX®} \)

**Frequency/Schedule of Treatment:**

**Normal Treatment Schedule:** Treatment is given on two consecutive days every four weeks for a minimum of seven treatment cycles (six months).

**Accelerated Treatment Schedule:** If the assessment of the patient during the fourth treatment cycle (approximately...
three months) reveals an increased skin score from the baseline score, the frequency of treatment may be increased to two consecutive treatments every two weeks. If a 25% improvement in the skin score is attained after four consecutive weeks, the regular treatment schedule may resume. Patients who are maintained in the accelerated treatment schedule may receive a maximum of 20 cycles. There is no clinical evidence to show that treatment with UVADEX® beyond six months or using a different schedule provides additional benefit. In study CTCL 3, 15 of the 17 responses were seen within six months of treatment and only two patients responded to treatment after six months.

**HOW SUPPLIED**
UVADEX® (methoxsalen) Sterile Solution 20 mcg/mL in 10 mL amber glass vials (NDC 64067-216-01), and cartons of 12 vials (NDC 64067-216-01). One vial of 10 mL contains 200 micrograms methoxsalen. The drug product must be stored between 59°F (15°C) and 86°F (30°C).

**REFERENCES**
3. National Study Commission on Cytotoxic Exposure-Recommendations for Handling Cytotoxic Agents. Available from Louis P. Jeffrey, Sc.D., Chairman, National Study Commission on Cytotoxic Exposure, Massachusetts College of Pharmacy and Allied Health Sciences, 179 Longwood Avenue, Boston, Massachusetts 02115.