November 12, 2021

Submitted electronically to PartBLCDComments@anthem.com

National Government Services Medical Policy Unit
P.O. Box 7108
Indianapolis, IN 46207-7108

RE: Proposed LCD DL37810: Genomic Sequence Analysis Panels in the Treatment of Solid Organ Neoplasms

Dear National Government Services Medical Policy Unit,

On behalf of the Community Oncology Alliance (COA), we appreciate the opportunity to submit this public comment for the Proposed LCD - Genomic Sequence Analysis Panels in the Treatment of Solid Organ Neoplasms (DL37810).

COA is an organization dedicated to advocating for the complex care and access needs of patients with cancer and the community oncology practices that serve them. COA is the only non-profit organization in the United States dedicated solely to independent community oncology practices, which serve the majority of Americans receiving treatment for cancer. COA's mission since its grassroots founding close to 20 years ago has been to ensure that patients with cancer receive quality, affordable, and accessible care in their own communities where they live and work, regardless of their racial, ethnic, or socioeconomic status.

We commend National Government Services (NGS) for initiating this proposed LCD and support the overall intent to increase access to technology to optimize the management of patients with advanced solid tumors. However, we have concerns regarding proposed indications and specific views documented in the Summary of Evidence listed in the proposed LCD in reference to Next Generation Sequence (NGS) Comprehensive Genomic Profile (CGP) testing.

COA is committed to providing solutions to the challenges that our nation’s cancer care system faces, including equitable access to diagnostic tests, treatments, and appropriate care utilization. In this comment letter, we provide details on our concerns about specific aspects of the proposed LCD, along with recommendations.

Specific Comments and Recommendations

(1) – “only when more limited (e.g., individual analyte or targeted panel (5-50 genes)) testing is insufficient”

We are extremely concerned that this language would minimize the true value of comprehensive NGS CGP and access to some of the greatest, lifesaving advancements in science and, more specifically, cancer care in the 21st century.

Limiting CGP testing to 51 genes or less will exclude assessment of DNA repair defects (HRD) and others as well as impedes calculating TMB (tumor mutational burden). The impact
will be denied access to FDA-approved therapies as somatic panel of 51 genes or less and typically does not contain genes like RAD 54L, BRCA, etc.

We reference the following list of FDA approved therapies and companion DNA repair defect mutants using NGS (Source: PMA P170019/S015: FDA Summary of Safety and Effectiveness Data):

<table>
<thead>
<tr>
<th>Tumor Type</th>
<th>Biomarker(s) Detected</th>
<th>Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-small cell lung cancer (NSCLC)</td>
<td><em>EGFR</em> exon 19 deletions and <em>EGFR</em> exon 21 L858R alterations</td>
<td>Gilotrifi® (afatinib), Iressa® (gefitinib), Tagrisso® (osimertinib), or Tarceva® (erlotinib)</td>
</tr>
<tr>
<td></td>
<td><em>EGFR</em> exon 20 T790M alterations</td>
<td>Tagrisso® (osimertinib)</td>
</tr>
<tr>
<td></td>
<td><em>ALK</em> rearrangements</td>
<td>Alecensa® (alectinib), Xalkori® (crizotinib), or Zykadia® (ceritinib)</td>
</tr>
<tr>
<td></td>
<td><em>BRAF</em> V600E</td>
<td>Tafinlar® (dabrafenib) in combination with Mekinist® (trametinib)</td>
</tr>
<tr>
<td></td>
<td><em>MET</em> single nucleotide variants (SNVs) and indels that lead to <em>MET</em> exon 14 skipping</td>
<td>TabrectaTM (capmatinib)</td>
</tr>
<tr>
<td>Melanoma</td>
<td><em>BRAF</em> V600E</td>
<td>Tafinlar® (dabrafenib) or Zelboraf® (vemurafenib)</td>
</tr>
<tr>
<td></td>
<td><em>BRAF</em> V600E and V600K</td>
<td>Mekinist® (trametinib) or Cotellic® (cobimetinib) in combination with Zelboraf® (vemurafenib)</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td><em>ERBB2</em> (HER2) amplification</td>
<td>Herceptin® (trastuzumab), Kadcyla® (ado-trastuzumab-emtansine), or Perjeta® (pertuzumab)</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td><em>KRAS</em> wild-type (absence of mutations in codons 12 and 13)</td>
<td>Erbitux® (cetuximab)</td>
</tr>
<tr>
<td></td>
<td><em>KRAS</em> wild-type (absence of mutations in exons 2, 3, and 4) and <em>NRAS</em> wild type (absence of mutations in exons 2, 3, and 4)</td>
<td>Vectibix® (panitumumab)</td>
</tr>
<tr>
<td>Ovarian Cancer</td>
<td><em>BRCA1/2</em> alterations</td>
<td>Lynparza® (olaparib) or Rubraca® (rucaparib)</td>
</tr>
<tr>
<td>Cholangiocarcinoma</td>
<td><em>FGFR2</em> fusions and select rearrangements</td>
<td>PemazyreTM (pemigatinib)</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>Homologous Recombination Repair (HRR) gene *(BRCA1,</td>
<td>Lynparza® (olaparib)</td>
</tr>
</tbody>
</table>
BRCA2, ATM, BARD1, BRIP1, CDK12, CHEK1, CHEK2, FANCL, PALB2, RAD51B, RAD51C, RAD51D and RAD54L alterations

- **Recommendation**: Remove the language in the proposed LCD limiting testing to 51 genes or less.

*(2) -- “not been previously tested with a CGP for the same cancer genetic content”*

We are concerned that limiting retesting of NGS CGP for the same cancer genetic content can miss evaluations of tumor heterogeneity or clonal evolution. In addition, mutagenesis is a dynamic process and limiting CGP for one time only will deny cancer patients access to precision medicine therapeutics.

- **Recommendation**: Modify language to eliminate the limit to testing in the same patient.

*(3) -- “Testing assays must be FDA approved, or if a laboratory developed test (LDT), have published, peer-reviewed studies supporting analytic validity.”*

We believe that this language would unnecessarily deny patients access to high-quality NGS CGP tests. When these tests have undergone evaluations by competent bodies and agencies such as the MolDX program, the quality, accurate analytical validity, and clinical performance have already been vetted.

- **Recommendation**: Modify language to include other states and agencies and MolDX to approve AV, CV ad CU to be reimbursable.

**Limiting Genetic Testing Worsens Health Disparities in Cancer**

As a more general comment on the proposed LCD, COA believes that limiting access to CGP testing will impact access to care and appropriate utilization that will worsen health care inequalities and inequities.

It is well known that there are profound and widespread disparities in cancer burden and cancer care among various groups, and COA seeks to address and diminish these disparities whenever possible. Precision medicine has the potential to improve the quality of health care by allowing practitioners to tailor prevention, diagnostic, and treatment strategies to individual patients.

In recent years, research breakthroughs, technological advances, and the decreasing cost of DNA sequencing have led to the wider adoption of genomic medicine. However, limiting the number of genes tested for diagnostic and therapeutic purposes will create a lack of representation in molecular information, precision medicine trial populations and ultimately cement long-standing knowledge gaps that drive health care disparities in precision health and genomic medicine.

- **Recommendation**: We hope that the proposed LCD will be considered in light of efforts to address cancer disparities and rare disease states by recommending NGS CGP to help address our nation’s diverse patient populations, particularly those who have faced health care disparities for far too long. NGS CGP facilitates the identification of novel uses of existing targeted therapies and/or eligibility for clinical trials with novel genetic alterations that can help address such populations.
Conclusion

COA appreciates the opportunity to comment on the Proposed LCD and trusts that the National Government Services will carefully consider the changes it has proposed and the impact they will have on the care Americans with cancer receive. Clearly, all patients should receive the very best, highest quality, and targeted cancer care that is in step with modern-day medicine.

We look forward to working with National Government Services leadership and staff to advance meaningful, patient-centered policies relating to cancer care. We are available to discuss any of our concerns and recommendations provided in this letter and thank you for your consideration.

Thank you again for the opportunity to comment on this proposed LCD DL37810.

Sincerely,

Kashyap Patel, MD
President

Ted Okon
Executive Director