

# Local Coverage Determination (LCD): MoIDX: Prolaris™ Prostate Cancer Genomic Assay for Men with Favorable Intermediate Risk Disease (L37226)

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## Contractor Information

<b>Contractor Name</b>	<b>Contract Type</b>	<b>Contract Number</b>	<b>Jurisdiction State(s)</b>
<a href="#">Wisconsin Physicians Service Insurance Corporation</a>	MAC - Part A	05101 - MAC A	J - 05 Iowa
<a href="#">Wisconsin Physicians Service Insurance Corporation</a>	MAC - Part B	05102 - MAC B	J - 05 Iowa
<a href="#">Wisconsin Physicians Service Insurance Corporation</a>	MAC - Part A	05201 - MAC A	J - 05 Kansas
<a href="#">Wisconsin Physicians Service Insurance Corporation</a>	MAC - Part B	05202 - MAC B	J - 05 Kansas
<a href="#">Wisconsin Physicians Service Insurance Corporation</a>	MAC - Part A	05301 - MAC A	J - 05 Missouri - Entire State
<a href="#">Wisconsin Physicians Service Insurance Corporation</a>	MAC - Part B	05302 - MAC B	J - 05 Missouri - Entire State
<a href="#">Wisconsin Physicians Service Insurance Corporation</a>	MAC - Part A	05401 - MAC A	J - 05 Nebraska
<a href="#">Wisconsin Physicians Service Insurance Corporation</a>	MAC - Part B	05402 - MAC B	J - 05 Nebraska
			Alaska Alabama Arkansas Arizona Connecticut Florida Georgia Iowa Idaho Illinois Indiana Kansas Kentucky Louisiana Massachusetts Maine Michigan Minnesota Missouri - Entire State Mississippi Montana North Carolina North Dakota Nebraska New Hampshire New Jersey Ohio Oregon Rhode Island South Carolina South Dakota Tennessee
<a href="#">Wisconsin Physicians Service Insurance Corporation</a>	MAC - Part A	05901 - MAC A	J - 05

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
<a href="#">Wisconsin Physicians Service Insurance Corporation</a>	MAC - Part A	08101 - MAC A	J - 08	Utah Virginia Virgin Islands Vermont Washington Wisconsin West Virginia Wyoming
<a href="#">Wisconsin Physicians Service Insurance Corporation</a>	MAC - Part B	08102 - MAC B	J - 08	Indiana
<a href="#">Wisconsin Physicians Service Insurance Corporation</a>	MAC - Part A	08201 - MAC A	J - 08	Michigan
<a href="#">Wisconsin Physicians Service Insurance Corporation</a>	MAC - Part B	08202 - MAC B	J - 08	Michigan
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## LCD Information

### Document Information

LCD ID: L37226  
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Retirement Date: N/A

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## CMS National Coverage Policy

Title XVIII of the Social Security Act (the "Act"), Section 1862(a)(1)(A). This section limits coverage and payment to those items and services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Title XVIII of the Social Security Act, Section 1833(e). This section prohibits Medicare payment for any claim that lacks the necessary information to process the claim.

42 C.F.R. § 410.32 "Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests: Condition."

Medicare Internet Online Manual Pub. 100-2 (Medicare Benefit Policy Manual), Chapter 15, Section 80, "Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests"

Medicare Internet Online Manual Pub. 100-4 (Medicare Claims Processing Manual), Chapter 16, Sections:  
50.5 Jurisdiction of Laboratory Claims  
60.12 Independent Laboratory Specimen Drawing  
60.2 Travel Allowance

Medicare Internet Online Manual Pub. 100-4 (Medicare Claims Processing Manual), Chapter 23, Section 10 "Reporting ICD Diagnosis and Procedure Codes"

## Coverage Guidance

### **Coverage Indications, Limitations, and/or Medical Necessity**

This contractor will provide limited coverage for the Prolaris™ prostate cancer assay (Myriad, Salt Lake City, UT) to help determine which patients with favorable intermediate risk, needle biopsy proven prostate cancer (as defined below), can be conservatively managed rather than treated with definitive surgery or radiation therapy.

### **Summary of Evidence**

In 2016, nearly 180,890 men in the US will be diagnosed with prostate cancer, which accounts for 10.7% of all new cancer diagnosis. More than 26,120 men will die from this disease representing 4.4% of all cancer deaths. Gratefully, 98.9% of men are surviving at 5 years.

Many men do not need treatment for their prostate cancer in as much as their prognosis is excellent even without treatment. However, physicians and patients struggle to know who can safely be monitored versus the subgroup that needs more aggressive treatment to achieve cure, recognizing that definitive treatment for localized prostate cancer can have lifelong morbidities.

Traditionally, clinicopathologic characteristics are utilized to determine risk and subsequent treatment. Risk categories for clinically localized prostate cancer include low-, intermediate-, or high-risk. The majority of men diagnosed with prostate cancer are categorized as low- or intermediate- risk. Within the intermediate-risk group, more recent recognition of clinical heterogeneity and variability in prognoses has led to a further subdivision into favorable (defined below as per NCCN 2017) and unfavorable intermediate-risk.

Several risk stratification approaches, including those from the NCCN and AUA, have been introduced to try to determine who is at risk of developing metastatic disease and who, if treated early, could avoid this outcome. A representative one taken from the NCCN, divides early prostate cancer into several groups based initially on life expectancy, with a second stratification using clinical exam, reassessment of life expectancy, biopsy (Gleason score), PSA and imaging.

These groups are detailed below:

	<b>Risk Category</b>			
	<b>Very Low</b>	<b>Low</b>	<b>Intermediate</b>	<b>High</b>
<b>Clinicopathologic Findings</b>	<p>T1c <b>AND</b></p> <ul style="list-style-type: none"> <li>Gleason score <math>\leq</math> 6/Gleason grade group 1 <b>AND</b></li> <li>PSA <math>\leq</math> 10 ng/mL <b>AND</b></li> <li><math>&lt; 3</math> prostate cores with tumor <b>AND</b></li> <li><math>\leq 50\%</math> tumor in any core <b>AND</b></li> <li>PSA density of <math>&lt; 0.15</math> ng/mL/g</li> </ul>	<ul style="list-style-type: none"> <li>T1-T2a <b>AND</b></li> <li>Gleason score <math>\leq</math> 6/Gleason grade group 1 <b>AND</b></li> <li>PSA <math>\leq</math> 10 ng/mL</li> </ul>	<p>T2b-T2c <b>OR</b></p> <ul style="list-style-type: none"> <li>Gleason score 3+4=<math>\leq</math> 7/Gleason grade group 2 <b>OR</b></li> <li>Gleason score 4+3=<math>\leq</math> 7/Gleason grade group 3 <b>OR</b></li> <li>PSA 10-20 ng/mL</li> </ul>	<p>T3a <b>OR</b></p> <ul style="list-style-type: none"> <li>Gleason Score 8/Gleason grade group 4 <b>OR</b></li> <li>Gleason score 9-10/Gleason grade group 5 <b>OR</b></li> <li>PSA <math>&gt; 20</math> ng/mL</li> </ul>
<b>Treatment Options</b>				
<b><math>\geq 20</math> y life expectancy</b>	<ul style="list-style-type: none"> <li>Active Surveillance</li> <li>RT or Brachy</li> <li>RP (<math>\pm</math> LND)</li> </ul>			
<b><math>\geq 10</math> y life expectancy</b>	<ul style="list-style-type: none"> <li>Active Surveillance</li> </ul>	<ul style="list-style-type: none"> <li>Active Surveillance</li> <li>RT or Brachy</li> <li>RP (<math>\pm</math> LND)</li> </ul>	<ul style="list-style-type: none"> <li>RP (<math>\pm</math> LND)</li> <li>RT <math>\pm</math> Adj Horm Brachy</li> <li>Brachy</li> </ul>	<ul style="list-style-type: none"> <li>RT + Adj Horm</li> <li>RT + Brachy <math>\pm</math> Adj Horm</li> <li>RP + LND</li> </ul>
<b><math>&lt; 10</math> y life expectancy</b>	<ul style="list-style-type: none"> <li>Observation</li> </ul>	<ul style="list-style-type: none"> <li>Observation</li> </ul>	<ul style="list-style-type: none"> <li>RT <math>\pm</math> Adj Horm Brachy</li> <li>Brachy</li> <li>Observation</li> </ul>	<ul style="list-style-type: none"> <li>NA</li> </ul>

**Table 1: NCCN 2017 V2 - Localized Prostate Cancer Risk Stratification and Treatment**

(PSA – Prostate Specific Antigen; RT – Radiation Therapy; RP – Radical Prostatectomy; LND – lymph node dissection; Adj Horm – Adjuvant Androgen Deprivation)

The treatment algorithm for intermediate risk patients found in the 2017 NCCN guidelines for Prostate Cancer includes footnote “o” on page PROS-4 stating that men with “favorable intermediate-risk prostate cancer (predominant Gleason grade 3 [i.e., Gleason score 3+4= $\leq$ 7/Gleason grade group 2], and percentage of positive biopsy cores  $< 50$  percent, and no more than one NCCN intermediate risk factor) can be considered for active surveillance”. The NCCN also acknowledges that such a choice “should be approached with caution, include informed decision-making, and use close monitoring for progression”.

Use of clinical/pathologic stratification and treatment approaches has led to high cure rates for early stage prostate cancer. Yet it is widely accepted that many men are over-treated to achieve the cure rate. In the PIVOT trial men with early prostate cancer, initially randomized to radical prostatectomy or observation, showed that over 12 years there was no difference in absolute mortality between the groups. However, this study was hampered by several problems including:

- Only 731 of 5023 eligible patients chose to participate in the study based on randomization criteria.
- In the group randomized to RP: only 85% of the men received definitive therapy (79% surgery; 6% other).
- In the observational group: 10% of the observation group received RP initially and additional 20% eventual received definitive treatment.
- Despite broad inclusion criteria, > 50% of patients had a PSA of <10 (median PSA of 7) and had biopsy proven T1c disease. Although there were a significant number of patients with Gleason score  $\geq 7$  (25%), 40% of men were classified initially as being low risk, and 30% were intermediate.

Although subgroups were small, it appears that high-risk groups (including those with PSA > 10) benefitted from RP. Furthermore, there was a trend for the intermediate risk patients to benefit from RP as well. The small number of patients willing to enter the study, and the high rate of crossover (both initially and subsequently) demonstrates the difficulty of doing observation trials in the United States.

Recent reports on prostate cancer diagnosis and management in the United States evaluated data from the US National Cancer Data Base and the Cancer of the Prostate Strategic Urologic Research Endeavor (CaPSURE) to summarize the use of various treatments, including changes over time. Although the use of active surveillance for men with low-risk prostate cancer increased over time, it was utilized in only 18.4 - 40% of patients despite societal guidelines supporting its use in this population. In the intermediate-risk group, active surveillance was pursued in only 4-8% of patients. The availability of molecular diagnostic tests that provide a more accurate prediction of oncologic endpoints like 10-year disease specific mortality, compared to standard clinical and pathologic features, provides an opportunity to identify men who may safely pursue active surveillance and increase physician/patient confidence in that choice. The benefits associated with active surveillance and foregoing immediate intervention for appropriate men include a reduction in treatment related complications and avoidance of adverse events like erectile dysfunction, urinary incontinence, bowel dysfunction, and depression.

### **Prolaris™ Prostate Cancer Assay Test Description**

Prolaris™ is an RNA based assay measuring the expression of 31 cell cycle progression (CCP) genes and 15 "housekeeping" genes that act as internal controls and normalization standards in each patient sample. The assay is performed on formalin fixed paraffin-embedded (FFPE) prostate cancer blocks. The assay results are reported as a numerical score along with accompanying interpretive information.

The Prolaris™ test report that is delivered to the ordering physician includes:

- The patient's Prolaris Score (i.e. cell cycle progression score or "CCP");
- The patient's estimated 10-year prostate cancer mortality risk based on his Prolaris™ Score in combination with his CAPRA score (the combined clinical-cell cycle risk score, or "CCR");
- A depiction of a threshold for prostate cancer mortality risk below which active surveillance may be safely considered.

The active surveillance threshold was developed based on the CCR score distribution in a training cohort of commercially tested men who might typically be considered for active surveillance according to the NCCN\*, based on their clinical characteristics alone (n = 505). The training cohort included men meeting the following criteria: Gleason score  $\leq 3+4$ ; PSA < 10 ng/ml; <25% positive cores; and T-stage  $\leq T2a$  (N=505). A threshold for the CCR score of 0.8 was conservatively selected such that 90% of the men in the training cohort had scores below the threshold. The threshold of 0.8 was then validated in two independent cohorts (combined n=765) of conservatively managed men with known outcomes for prostate cancer specific mortality (PCM). The Prolaris™ Score was a strong prognostic indicator in both validation cohorts, based on previous publications (See references 2 & 3). The threshold was able to dichotomize men into significantly different risk groups. There were no prostate cancer deaths in the group of men with CCR scores below the threshold of 0.8. The CCR score of 0.8 corresponded to a 10-year predicted risk of PCM of about 3%. In summary, the threshold for the CCR score of 0.8 distinguishes men with prostate cancer who may safely pursue active surveillance from those who may not be good candidates.

\*NCCN Guidelines state that men with favorable intermediate-risk prostate cancer may be considered for active surveillance. Our training cohort included a conservative version of favorable intermediate including  $\leq 3+4$  with all other low-risk factors.

## Test Performance

The clinical performance of this assay was assessed in several retrospective validation studies. These include two British cohorts of men diagnosed with prostate cancer on biopsy and then treated conservatively; and an additional cohort of men diagnosed by TURP and conservatively managed. Further validation was performed in various other cohorts including men who underwent radical prostatectomy, and men treated with definitive radiotherapy. The Prolaris™ cell cycle progression score (CCP) was found to be an independent and more robust prognostic factor for disease related death than traditional clinicopathologic factors although disease stage and Gleason score consistently portended a more negative prognostic picture.

Due to the difficulty in obtaining prospective data in early prostate cancer (outcomes take decades to develop, hard to accrue patients to a conservatively managed arm in the US), and given the unmet need, clinical utility can be extrapolated from this retrospective data. Doing so is not without shortcomings. It is unclear how the British cohorts were followed or who went on to receive definitive therapy inside the observation groups. The U.K. standard of care for treating these prostate cancer patients is different. In the U.S. conservatively managed patients is not the common occurrence. Furthermore, the long time period to determine outcomes and the lack of tissue specimens make review of a U.S. cohort unlikely if not impossible for many years.

In several of the published cohorts including the conservatively managed patients, multivariate analysis identified CCP score and Gleason score as the only values that consistently identify increased risk of death from prostate cancer. It also should be noted that the cancer related death rate in these retrospective studies of conservatively managed patients was much greater than would be expected in the United States with 19.3% of the patients with the lowest CCP succumbing to disease. Subset analysis suggests that if the patients with higher risk disease (Gleason score > 7; higher stage) had received definitive treatment (like the current standard in the US) the rate succumbing to disease would likely be substantially better.

The potential usefulness of this test is that it allows physicians to determine which patients with early prostate cancer are candidates for active surveillance or observation and are more likely to have a good outcome without needing to receive definitive treatment. For patients with favorable intermediate risk disease, the use of Prolaris™ determines which patients have more or less aggressive disease than predicted by clinical features alone and may serve as a component of the informed decision-making process.

## Criteria for Coverage

The Prolaris™ assay is covered for men with favorable intermediate risk prostate cancer only when the following clinical conditions are met:

- Needle biopsy with localized adenocarcinoma of prostate (no clinical evidence of metastasis or lymph node involvement), and
- FFPE prostate biopsy specimen with at least 0.5 mm of cancer length, and
- Patients with favorable intermediate-risk disease, defined by the NCCN as follows:
  - Predominant Gleason grade 3 (i.e. Gleason score 3+4=7), percentage of positive cores <50%, and no more than 1 NCCN intermediate-risk factor)  
NCCN intermediate risk factors include T2b-T2c, Gleason score 7, and PSA10-20 ng/mL
- Patient has an estimated life expectancy of greater than or equal to 10 years, and
- Patient is a candidate for and is considering conservative therapy and yet would be eligible for definitive therapy (radical prostatectomy, radiation therapy or brachytherapy), and
- Result will be used to determine treatment between definitive therapy and conservative management, and
- Patient has not received pelvic radiation or androgen deprivation therapy prior to the biopsy, and
- Patient is monitored for disease progression according to established standard of care, and

## Analysis of Evidence (Rationale for Determination)

Level of Evidence

Quality – Moderate

Strength – Moderate

Weight –Moderate

This contractor recognizes that the evidence of clinical utility for the use of Prolaris™ for patients with favorable intermediate risk, needle biopsy proven prostate cancer that can be conservatively managed rather than treated with definitive surgery or radiation therapy is promising at the current time. However, this contractor believes that the endpoints (see below) in the clinical registry currently in progress will generate sufficient data to

demonstrate the utility of this test. Continued coverage for Prolaris™ testing for favorable intermediate risk patients is dependent on annual review of prospectively derived scientific data and peer-reviewed publications that demonstrate enhanced clinical utility for Prolaris™ testing in this subgroup of patients.

Studies that demonstrate the following are currently underway by Myriad by demonstrating:

1. Favorable intermediate risk patients with low Prolaris™ scores who choose AS are not at high risk of definitive treatment during monitoring for disease progression.
  - Within this group of patients, the rate of definitive treatment intervention is expected to be <20%.
  - In the absence of a universally accepted timeframe for repeat biopsies within existing AS recommendations, men should be monitored for disease progression per NCCN guidelines v3.2016 "Principles of Active Surveillance", with the expectation of a repeat biopsy within 18 months of enrollment.
  - For each patient who pursues definitive treatment (after initially pursuing AS), the time on active surveillance and the reason for intervention will be collected, including:
    - Increase in tumor volume or Gleason score on subsequent biopsy
    - For patients who choose radical prostatectomy, the pathology report from the surgical specimen will be recorded
    - Imaging suggestive of disease progression (Response Evaluation Criteria in Solid Tumors; RECIST)
    - Patient choice in absence of the above
2. Among the group of patients described in 1) above, those who proceed to definitive treatment will not be at a >20% risk of disease progression, as defined by biochemical recurrence, metastases, or DSM.
3. Toward further demonstration of clinical utility, additional data collected will include
  - The rate of AS, and
  - Subsequent definitive treatment intervention, and
  - Disease progression among men with favorable intermediate risk prostate cancer who do NOT receive a Prolaris™ test.

This additional data is expected to firmly establish clinical utility by identifying men with intermediate risk prostate cancer with a low Prolaris™ score who can be comfortable with AS and avoid unnecessary procedures and/or interventions.

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## [Coding Information](#)

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

Revenue Codes:

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N/A

CPT/HCPCS Codes

**Group 1 Paragraph:** N/A

**Group 1 Codes:**

ICD-10 Codes that Support Medical Necessity

**Group 1 Paragraph:** N/A

**Group 1 Codes:**

ICD-10 Codes	Description
C61	Malignant neoplasm of prostate

ICD-10 Codes that DO NOT Support Medical Necessity N/A

ICD-10 Additional Information

NA

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## [General Information](#)

Associated Information

N/A

Sources of Information

N/A

Bibliography

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## [Revision History Information](#)



## **Associated Documents**

Attachments N/A

Related Local Coverage Documents Article(s) [A55645 - Response to Comments: MoIDX: Prolaris™ Prostate Cancer Genomic Assay for Men with Favorable Intermediate Risk Disease \(DL37226\)](#). LCD(s) [DL37226 - MoIDX: Prolaris™ Prostate Cancer Genomic Assay for Men with Favorable Intermediate Risk Disease](#)

Related National Coverage Documents N/A

Public Version(s) Updated on 07/21/2017 with effective dates 09/16/2017 - N/A [Back to Top](#)

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## **Keywords**

N/A Read the [LCD Disclaimer](#) [Back to Top](#)