

Speciality Guideline Management

Kimmtrak

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Kimmtrak	tebentafusp-tebn

Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-approved Indication¹

Kimmtrak is indicated for the treatment of HLA-A*02:01-positive adult patients with unresectable or metastatic uveal melanoma.

All other indications are considered experimental/investigational and not medically necessary.

Documentation

Submission of the following information is necessary to initiate the prior authorization review:
medical record documentation of HLA-A*02:01 phenotype.

Reference number(s)
5149-A

Coverage Criteria

Uveal Melanoma¹

Authorization of 12 months may be granted for treatment of uveal melanoma when all of the following criteria are met:

- The member is HLA-A*02:01-positive
- The disease is unresectable or metastatic

Continuation of Therapy

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

References

1. Kimmtrak [package insert]. Conshohocken, PA: Immunocore Commercial LLC; June 2024.