Reference number(s)
5149-A

SPECIALTY GUIDELINE MANAGEMENT

KIMMTRAK (tebentafusp-tebn)

POLICY

I. 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 Indication
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.

II. DOCUMENTATION

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

III. CRITERIA FOR INITIAL APPROVAL

Uveal Melanoma
Authorization of 12 months may be granted for treatment of uveal melanoma when all of the following criteria are met:
1. The member is HLA-A*02:01-positive
2. The disease is unresectable or metastatic

IV. CONTINUATION OF THERAPY

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

V. REFERENCES

1. Kimmtrak [package insert]. Conshohocken, PA: Immunocore Commercial LLC; November 2022.