Reference number(s)
5150-A

Standard Medicare Part B 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 Indication[1]

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

All other indications will be assessed on an individual basis. Submissions for indications other than those listed in this criteria should be accompanied by supporting evidence from Medicare approved compendia.

Documentation

The following documentation must be available, upon request, for all submissions:

For initial requests: medical record documentation of HLA-A*02:01 phenotype.

Coverage Criteria

Uveal Melanoma[1]

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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

All members (including new members) requesting authorization for continuation of therapy must be currently receiving therapy with the requested agent.

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

- The member is currently receiving therapy with the requested medication
- The requested medication is being used to treat an indication listed in the coverage criteria section
- The member is receiving benefit from therapy. Benefit is defined as:
  - No evidence of unacceptable toxicity while on the current regimen and
  - No evidence of disease progression while on the current regimen

Summary of Evidence

The contents of this policy were created after examining the following resources:

- The prescribing information for Kimmtrak
- The available compendium
  - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
  - Micromedex DrugDex
  - American Hospital Formulary Service- Drug Information (AHFS-DI)
  - Lexi-Drugs
  - Clinical Pharmacology
- NCCN Guideline: Uveal melanoma

After reviewing the information in the above resources, the FDA-approved indications listed in the prescribing information for Kimmtrak are covered.

Explanation of Rationale

Support for FDA-approved indications can be found in the manufacturer's prescribing information.

References

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

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