| Division: Pharmacy Policy | Subject: Prior Authorization Criteria |
|---|---|
| Original Development Date:<br>Original Effective Date:<br>Revision Date: | June 16, 2022 |

# KIMMTRAK® (tebentafusp-tebn)

**LENGTH OF AUTHORIZATION**: Up to 6 months

**REVIEW CRITERIA**:

- Patient must be ≥ 18 years of age.
- Patient must have a documented diagnosis of uveal melanoma that is:
  - Metastatic or unresectable; **AND**
  - HLA-A*02:01 genotype positive *(diagnostic testing results must be included with submission)*

**CONTINUATION OF THERAPY**:

- Patient met initial review criteria; **AND**
- Documentation of improved clinical response with no signs of disease progression; **AND**
- Patient has not experienced any treatment-restricting adverse effects; **AND**
- Dosing is appropriate as per labeling or is supported by compendia.

**DOSING AND ADMINISTRATION:**

- Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/
- Dosage form: 100 mcg/0.5 mL solution in a single-dose vial