



Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: 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