



Division: Pharmacy Policy	Subject: State of Florida's Agency for Health Care Administration's 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  $\geq$  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