

## Clinical Policy: Tebentafusp-tebn (Kimmtrak)

Reference Number: LA.PHAR.575

Effective Date:

Last Review Date: 05.01.23

Line of Business: Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

\*\*Please note: This policy is for medical benefit\*\*

### Description

Tebentafusp-tebn (Kimmtrak®) is a bispecific gp100 peptide-HLA-directed CD3 T cell engager.

### FDA Approved Indication(s)

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

### Policy/Criteria

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of Louisiana Healthcare Connections® that Kimmtrak is **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Uveal Melanoma (must meet all):

1. Diagnosis of unresectable or metastatic uveal melanoma;
2. Prescribed by or in consultation with an oncologist;
3. Age  $\geq$  18 years;
4. Disease is HLA-A\*02:01-positive;
5. Request meets one of the following (a or b):\*
  - a. Dose does not exceed 20 mcg (1 vial) on Day 1, 30 mcg (1 vial) on Day 8, 68 mcg (1 vial) on Day 15, and 68 mcg (1 vial) weekly thereafter;
  - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

*\*Prescribed regimen must be FDA-approved or recommended by NCCN*

**Approval duration:** 6 months

##### B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND

## CLINICAL POLICY

### Tebentafusp-tebn

criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: LA.PMN.53 for Medicaid.

## II. Continued Therapy

### A. Uveal Melanoma (must meet all

1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Kimmtrak for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):\*
  - a. New dose does not exceed 68 mcg (1 vial) weekly;
  - b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

*\*Prescribed regimen must be FDA-approved or recommended by NCCN*

**Approval duration:** 12 months

### B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: LA.PMN.53 for Medicaid.

**Approval duration:** Duration of request or 6 months (whichever is less)

## III. Diagnoses/Indications for which coverage is NOT authorized:

- ### A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – LA.PMN.53 for Medicaid or evidence of coverage documents.

## IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

CRS: cytokine release syndrome

FDA: Food and Drug Administration

*Appendix B: Therapeutic Alternatives*

Not applicable.

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): none reported
- Boxed warning(s): cytokine release syndrome (CRS)

## V. Dosage and Administration

## CLINICAL POLICY

### Tebentafusp-tebn

Indication	Dosing Regimen	Maximum Dose
For treatment of HLA-A*2:01-positive unresectable or metastatic uveal melanoma	20 mcg on Day 1, 30 mcg on Day 8, 68 mcg on Day 15, then 68 mcg once every week thereafter	68 mcg /week

#### VI. Product Availability

Injection: 100 mcg/0.5 mL vial

#### VII. References

1. Kimmtrak Prescribing Information. Conshohocken, PA: Immunocore Commercial Limited; January 2022. Available at: <https://www.kimmtrak.com/>. Accessed February 16, 2022.
2. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2022. Available at: <http://www.clinicalpharmacology-ip.com/>. Accessed February 16, 2022.
3. National Comprehensive Cancer Network. Melanoma: Uveal Version 2.2021 Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/uveal.pdf](https://www.nccn.org/professionals/physician_gls/pdf/uveal.pdf). Accessed February 10, 2022.

#### Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
C9399 (NOC)*	Unclassified drugs or biologicals (hospital outpatient use)
J9274	Injection, tebentafusp-tebn, 1 mcg
J9999 (NOC)	Not otherwise classified, antineoplastic drugs

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Policy created.	05.01.23	

#### Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

## CLINICAL POLICY

### Tebentafusp-tebn

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This clinical policy is the property of LHCC. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

©2023 Louisiana Healthcare Connections. All rights reserved. All materials are exclusively owned by Louisiana Healthcare Connections and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Louisiana Healthcare Connections. You may not alter or remove any trademark, copyright or other notice contained herein. Louisiana Healthcare Connections is a registered trademark exclusively owned by Louisiana Healthcare Connections.