STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Kimmtrak (tebentafusp-tebn)
PAM-050

Iowa Medicaid Program:	Prior Authorization	**Effective Date:**	10/01/2022
Revision Number:	2	**Last Rev Date:**	01/19/2024
Reviewed By:	Medicaid Medical Director	**Next Rev Date:**	01/17/2025
Approved By:	Medicaid Clinical Advisory Committee	**Approved Date:**	01/20/2023

Overview

Medication:[1]	tebentafusp-tebn
Brand Name:	Kimmtrak®
Pharmacologic Category:	Bispecific gp100 peptide-HLA-directed CD3 T cell engager

FDA-Approved Indication(s):	Treatment of HLA-A*02:01-positive adult patients with unresectable or metastatic uveal melanoma (mUM).
	Patient Selection
	Select patients for treatment of unresectable or metastatic uveal melanoma with Kimmtrak® based on a positive HLA-A*02:01 genotyping test.
	• *An FDA-approved test for the detection of HLA-A*02:01 genotyping is not currently available.*
	• HCPCS 81381 can be used for the lab to detect HLA-A*02:01 genotyping.
	  ○ 81381: HLA class I typing, high resolution; one allele or allele group, each.
	  ○ A broader HLA panel is not necessary, as no other HLA gene/subtypes can be used to determine patient eligibility for Kimmtrak®.

How Supplied:	Single-dose vial; 100 mcg in 0.5 mL
Dosage and Administration:	Dosage: 20 mcg on Day 1, 30 mcg on Day 8, 68 mcg on Day 15, then 68 mcg once weekly thereafter until unacceptable toxicity or disease progression. Administration: • Administer the first three infusions of Kimmtrak® in an appropriate healthcare setting by intravenous infusion over 15-20 minutes. Monitor patients during the infusion and for at least 16 hours after the infusion is complete. • If the patient does not experience Grade 2 or worse hypotension (requiring medical intervention) during or after the third infusion, administer subsequent doses in an appropriate ambulatory care setting, and monitor patients for a minimum of 30 minutes following each of these infusions.
Benefit Category:	Medical

Black Box Warning: Cytokine release syndrome (CRS)

CRS, which may be life threatening, occurred in patients receiving Kimmtrak®. Manifestations of CRS may include fever, hypotension, hypoxia, chills, nausea, vomiting, rash, elevated transaminases, fatigue, and headache. CRS (≥ Grade 2) occurred in 77 percent of patients in Study IMCgp100-202 who received Kimmtrak®. Among patients who received Kimmtrak®, 23 percent received systemic corticosteroids for at least one infusion, 8 percent received supplemental oxygen during at least one infusion, and 0.8 percent received a vasopressor for at least one infusion. CRS led to permanent discontinuation in 1.2 percent of patients.

In Study IMCg100-202, 60 percent of patients experienced ≥ Grade 2 CRS with more than one infusion, with the median number of events being 2 (range 1 - 12). The majority (84 percent) of episodes of CRS started the day of infusion. Among cases that resolved, the median time to resolution of CRS was two days.

Descriptive Narrative

Uveal melanoma (UM) is a rare malignancy that arises from melanocytes within the uveal tract of the eye (includes the iris, ciliary body, and choroid). UM comprises approximately 85 percent of all ocular melanomas, with the remainder arising in the conjunctiva or (rarely) the orbit.

Local treatment for primary uveal melanoma is effective in preventing recurrence in over 90 percent of cases, yet up to 50 percent of patients are at risk for metastatic disease. It is rare for patients diagnosed with UM to have detectable metastatic disease at the time of primary tumor diagnosis (occurs in less than 4 percent of patients diagnosed with UM). Most of the patients who do develop metastatic UM do so within 5 to 7 years of treatment to the primary eye tumor, with a median time of approximately 3 years. Metastases can also appear after a decade or longer.[2,3]

Guidelines

As new and emerging therapies are rapidly coming to market, oncology treatment recommendations and guidelines are constantly changing. To keep up with these changes, the National Comprehensive Cancer Network (NCCN) publishes guidelines which are developed and updated by 60 individual panels, comprising over 1,660 clinicians and oncology researchers from the 31 NCCN Member Institutions.[4]

The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) are a work in progress that may be refined as often as new significant data becomes available. To view the most recent and complete version of the guideline, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way.

The information referenced at the time of this policy writing/revision is from:

- NCCN Guidelines for Melanoma: Uveal (Version 1.2023 – May 4, 2023)[5]

NCCN Guidelines® Recommendation(s) for tebentafusp-tebn (Kimmtrak®) in uveal melanoma
(1) Systemic therapy for metastatic or unresectable disease, HLA-A*02:01-positive A. Tebentafusp-tebn (Kimmtrak®): Category 1, preferred therapy [a]
[a] A phase III randomized trial was conducted in previously untreated HLA-A*02:01-positive, metastatic uveal melanoma. Patients were randomized to receive tebentafusp-tebn (a bispecific protein) or investigator's choice of either pembrolizumab, ipilimumab, or dacarbazine. Treatment with tebentafusp-tebn resulted in longer overall survival compared to control therapy. Agents that are effective for metastatic cutaneous melanoma may be used as first-line therapy for HLA-A* 02:01-negative disease and after disease progression with first-line use of tebentafusp-tebn for HLA-A* 02:01-positive disease. If disease is confined to the liver, regional therapies such as chemoembolization, radioembolization, or immunoembolization should be considered. Since tebentafusp-tebn response rates are low, symptomatic patients may be better palliated by liver-directed treatment first or their disease may respond better to ipilimumab/nivolumab.

NCCN Categories of Evidence and Consensus (all recommendations are category 2A unless otherwise indicated)	
Category 1	Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2A	Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2B	Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
Category 3	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

NCCN Categories of Preference (all recommendations are considered appropriate)	
Preferred intervention	Interventions that are based on superior efficacy, safety, and evidence; and, when appropriate, affordability.
Other recommended intervention	Other interventions that may be somewhat less efficacious, more toxic, or based on less mature data; or significantly less affordable for similar outcomes.
Useful in certain circumstances	Other interventions that may be used for select patient populations (defined with recommendation).

Eastern Cooperative Oncology Group (ECOG) Performance Status[6]

Developed by the Eastern Cooperative Oncology Group (ECOG), now part of the ECOG-ACRIN Cancer Research Group, and published in 1982, the ECOG Performance Status Scale describes a patient's level of functioning in terms of their ability to care for themself, daily activity, and physical ability (walking, working, etc.). It is used by doctors and researchers to assess how a patient's disease is progressing, assess how the disease affects the daily living abilities of the patient, and determine appropriate treatment and prognosis.

GRADE	ECOG PERFORMANCE STATUS [Synonyms: WHO/Zubrod score]
0	Fully active, able to carry on all pre-disease performance without restriction.
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.
2	Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours.
3	Capable of only limited self-care; confined to bed or chair more than 50% of waking hours.
4	Completely disabled; cannot carry on any self-care; totally confined to bed or chair.
5	Dead.

Criteria

Prior authorization is required.

Kimmtrak® is considered medically necessary when **ALL** of the following are met:

1. Diagnosis of unresectable or metastatic uveal melanoma; **AND**
2. Member is HLA-A*02:01-positive; **AND**
3. Member is 18 years of age or older; **AND**
4. Member has an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1; **AND**
5. Prescribed by, or in consultation with, an oncologist; **AND**
6. Request meets one of the following (a or b):
    a. Regimen prescribed does not exceed 20 mcg on day 1, 30 mg on day 8, 68 mcg on day 15, and then 68 mcg once weekly thereafter until unacceptable toxicity or disease progression; or
    b. Regimen is supported by clinical practice guidelines (i.e., must be recommended in NCCN Guidelines®). Supporting clinical documentation must be provided with any request for which regimen prescribed does not align with FDA-approved labeling.

Kimmtrak® is considered medically necessary for continuation of therapy when **ALL** of the following are met:

1. Member is currently receiving medication through the Iowa Medicaid benefit or has previously met initial approval criteria; **AND**
2. Documentation of positive clinical response to therapy, as demonstrated by tumor response or lack of disease progression, and an acceptable toxicity profile; **AND**
3. Prescribed by, or in consultation with, an oncologist; **AND**
4. Request meets one of the following (a or b):
    a. Regimen prescribed does not exceed 68 mcg once weekly until unacceptable toxicity or disease progression; or
    b. Regimen is supported by clinical practice guidelines (i.e., must be recommended in NCCN Guidelines®). Supporting clinical documentation must be provided with any request for which regimen prescribed does not align with FDA-approved labeling.

Approval Duration and Quantity Limits

	Initial Authorization	Subsequent Authorization(s)
Approval Duration	6 months	12 months
Quantity Limits	20 mcg on day 1; 30 mcg on day 8; 68 mcg on day 15; then 68 mcg once weekly thereafter	68 mcg once weekly

Coding and Product Information

The following list(s) of codes and product information are provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS code is inappropriate.

HCPCS	Description
J9274	Injection, tebentafusp-tebn, 1 mcg
81381	HLA Class I typing, high resolution (i.e., alleles or allele groups); one allele or allele group (e.g., B*57:01P), each

ICD-10	Description
C69.30 – C69.62	Malignant neoplasm of unspecified choroid

NDC	Labeler	Dosage	Pkg Size	Pkg Qty	Units/Pkg
80446-0401-01	Immunocore Commercial LLC	1 mcg	1	EA	100

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.

3. Medical technology is constantly evolving, and Iowa Medicaid reserves the right to review and update medical policy on an annual or as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. Medical necessity guidelines are developed for selected physician-administered medications found to be safe and proven to be effective in a limited, defined population or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

[1] Kimmtrak prescribing information (11-2022). Immunocore Commercial LLC: Conshohocken, PA. Available online at www.kimmtrakhcp.com. Accessed December 17, 2023.

[2] Harbour JW, Shih HA. Initial management of uveal and conjunctival melanomas. Shah S, ed. UpToDate. Waltham, MA: UpToDate Inc. www.uptodate.com. Accessed December 9, 2022.

[3] Carvajal RD, Harbour JW. Metastatic uveal melanoma. Shah S, ed. UpToDate. Waltham, MA: UpToDate Inc. www.uptodate.com. Accessed December 9, 2022.

[4] National Comprehensive Cancer Network (NCCN). Development and Update of Guidelines. Available online at www.nccn.org. Accessed October 11, 2023.

[5] Referenced from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Melanoma: Uveal V.1.2023 – May 4, 2023. Accessed December 17, 2023. The NCCN Guidelines are a work in progress that may be refined as often as new significant data becomes available. To view the most recent and complete version of the guideline, go online to NCCN.org.

[6] Oken M, Creech R, Tormey D, et al. Toxicity and response criteria of the Eastern Cooperative Oncology Group. Am J Clin Oncol. 1982;5:649-655.

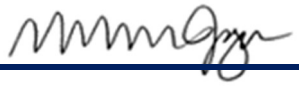
Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]			
Signature			

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]			
Signature			

Change Date	Changed By	Description of Change	Version
01/19/2024	CAC	Annual review. Updated NCCN Guidelines to include amended trial information included in the most recent version of the guidelines. Added dosing information into criteria.	2
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
01/20/2023	CAC	Criteria implementation.	1
Signature William (Bill) Jagiello, DO			

CAC = Medicaid Clinical Advisory Committee