OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

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Kimmtrak® (Tebentafusp-tebn) Prior Authorization Form

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

Physician billing (HCPCS code:_____***)*** ***Start Date (or date of next dose):*** _____

Dose:_____ ***Regimen:***_____

Billing Provider Information

Provider NPI:_____ ***Provider Name:***_____

Provider Phone:_____ ***Provider Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:
   - ☐ **Unresectable or metastatic uveal melanoma**
     a. Is there a positive expression of HLA-A*02:01 genotype? Yes ☐ No ☐
   - ☐ **If diagnosis is not listed above, please indicate diagnosis:** _____

Additional Information: _____

_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on tebentafusp-tebn therapy?
   Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to tebentafusp-tebn therapy?
   Yes☐ No☐
   a. If yes, please specify adverse reactions:_____

Additional information: _____

_____

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_____

Prescriber Signature: _____ **Date:**_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Failure to complete this form in full will result in processing delays. Please do not send in chart notes. Specific information will be requested if necessary.*

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**