Bimzelx (bimekizumab-bkzx)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DATE OF BIRTH:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PATIENT INSURANCE ID NUMBER:		

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**	
NPI NUMBER:	**DEA NUMBER:**	
PHONE NUMBER:	**FAX NUMBER:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page

Bimzelx (bimekizumab-bkzx)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Ankylosing spondylitis ☐ Plaque psoriasis ☐ Psoriatic arthritis ☐ Non-radiographic axial spondyloarthritis ☐ Hidradenitis Suppurativa ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

Is the prescriber a Dermatologist? ☐ **Yes** ☐ **No**

Is the prescriber a Rheumatologist? ☐ **Yes** ☐ **No**

Will the patient use drug with another biologic response modifier or immunomodulatory agent? ☐ **Yes** ☐ **No**

Has the patient tried and had an inadequate response to a three month trial of the biosimilar for Humira- adalimumab-aacf? ☐ **Yes** ☐ **No (Please submit documentation)**

<u>For Initial Request and diagnosis of Plaque Psoriasis</u>:

Is patient greater than or equal to 120kg? ☐ **Yes** ☐ **No**

If patient is greater than or equal to 120kg, will the patient be dosed every 8 weeks? ☐ **Yes** ☐ **No**

If patient is greater than or equal to 120kg, will the patient be dosed every 4 weeks? ☐ **Yes** ☐ **No**

Does the patient have plaques covering ≥ 10% of their body surface area (BSA)? ☐ **Yes** ☐ **No (Please submit documentation)**

Bimzelx (bimekizumab-bkzx)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Does patient have ≤ 10% of BSA with involvement of palms, soles, head and neck, or genitalia which causes disruption of normal activities? ☐ **Yes** ☐ **No (Please submit documentation)**

Is topical therapy no longer tolerated or effective with agents such as corticosteroids, anthralin, calcipotriene, or Tazarotene for thepatient? ☐ **Yes** ☐ **No (Please submit documentation)**

Select if the patient has had previous treatment failure with the following Please submit documentation.

- ☐ **Phototherapy**
- ☐ **Psoralens with UVA light (PUVA)**
- ☐ **UVB with coal tar**

Has the patient had previous treatment failure with an oral systemic therapy (e.g., acitretin, methotrexate or cyclosporine)? ☐ **Yes** ☐ **No**

If "no" to the above question, does the patient have a contraindication to ALL oral systemic treatments?* ☐ **Yes** ☐ **No**

***Documentation of a contraindication to ALL oral systemic treatments must be submitted*.**

For ankylosing spondylitis, also answer the following:

Has the patient had an adequate trial and failure of at least two non-steroidal anti-inflammatory agents (NSAIDs) or is use with these agents contraindicated? ☐ **Yes** ☐ **No**

If "yes" to the above question, document the agent(s) that have been tried and/or contraindications to therapy: _____

Has the patient been treated with methotrexate AND has had adequate trial and failure of one NSAID? ☐ **Yes** ☐ **No**

If "yes" to the above question, document the agent(s) that have been tried :

_____

For psoriatic arthritis, also answer the following:

Has the patient had at least a 3 month trial and failed previous therapy with an oral non-biologic disease modifying anti-rheumatic agent (DMARD) (e.g., methotrexate, azathioprine (Imuran), sulfasalazine (Azulfidine), or leflunomide (Arava))? ☐ **Yes** ☐ **No**

Is the patient unable to take the prerequisite non-biologic DMARD due to their chronic liver disease (such as chronic hepatitis, fatty liver,nonalcoholic steatohepatitis/NASH, or elevated liver enzymes)? ☐ **Yes** ☐ **No**

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

If "no" to the above question, provide the rationale as to why the patient has not taken the prequisite non-biologic DMARD: _____
_____

For <u>non-radiographic axial spondyloarthritis</u>, also answer the following:

Does the patient have objective signs of inflammation by presence of sacroiliitis on MRI imaging results? ☐ **Yes** ☐ **No (Please submit MRI imaging report)**

Does the patient have objective signs of inflammation by presence of an elevated C-reactive protein level? ☐ **Yes** ☐ **No (Please submit lab report)**

Has the patient had an inadequate response to at least two different NSAIDs? ☐ **Yes** ☐ **No (Please submit documentation)**

Does the patient have radiographic (x-ray) evidence of sacroiliitis (grade 2 or greater bilaterally OR grade 3 or higher unilaterally) ☐ **Yes** ☐ **No (Please submit imaging (x-ray) report)**

<u>Reauthorization</u>:
If this is a reauthorization request, answer the following questions:

Is the patient continuing to have a positive clinical response and remission of disease is maintained with continued use?* ☐ **Yes** ☐ **No (*Must be confirmed by provided chart notes)**

Will the patient use drug with another biologic response modifier or immunomodulatory agent? ☐ **Yes** ☐ **No**

Is prescriber a dermatologist rheumatologist? ☐ **Yes** ☐ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Bimzelx (bimekizumab-bkzx)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909