

USFHP Prior Authorization Request Form for
bimekizumab-bkzx (Bimzelx, Bimzelx autoinjector)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Prior authorization does not expire. Clinical documentation may be required

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
_____	_____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Taltz is the Department of Defense's preferred interleukin-17 (IL-17) agent. Please acknowledge a trial of Humira, Taltz, and Cosentyx is required before Bimzelx.	☐ Acknowledge Proceed to question 2	
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question 3	☐ No STOP Coverage not approved
3. What is the diagnosis or indication?	☐ Moderate to severe plaque psoriasis in a patient who is a candidate for systemic therapy or phototherapy - Proceed to question 4 ☐ Active ankylosing spondylitis (AS) - Proceed to question 5 ☐ Active non-radiographic axial spondyloarthritis (nr-AxSpA) with objective signs of inflammation - Proceed to question 5 ☐ Active psoriatic arthritis - Proceed to question 4 ☐ Active hidradenitis suppurativa - Proceed to question 7 ☐ Other diagnosis or indication – STOP Coverage not approved	
4. Has the patient had an inadequate response to non-biologic systemic therapy (for example, methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], etc.)?	☐ Yes Proceed to question 6	☐ No STOP Coverage not approved

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5. Has the patient had an inadequate response to at least two nonsteroidal anti-inflammatory drugs (NSAIDs) over a period of at least two months?	☐ Yes Proceed to question 6	☐ No STOP Coverage not approved
6. Has the patient tried and had an inadequate response to, experienced an adverse reaction to, or has a contraindication to Taltz that is not expected to occur with Bimzelx?	☐ Yes Proceed to question 7	☐ No STOP Coverage not approved
7. Has the patient tried and had an inadequate response to, experienced an adverse reaction to, or has a contraindication to Humira that is not expected to occur with Bimzelx?	☐ Yes Proceed to question 8	☐ No STOP Coverage not approved
8. Has the patient tried and had an inadequate response to, experienced an adverse reaction to, or has a contraindication to Cosentyx that is not expected to occur with Bimzelx?	☐ Yes Proceed to question 9	☐ No STOP Coverage not approved
9. Will the patient be receiving any other targeted immunomodulatory biologics with bimekizumab, including but not limited to the following: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, JAK inhibitors?	☐ Yes STOP Coverage not approved	☐ No Sign and date below

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date

[30 April 2025]