US Family Health Plan
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**

Prior authorization does not expire.

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. Is the patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. What is the diagnosis or indication?	☐ moderate to severe plaque psoriasis in patients who are candidates for phototherapy or systemic therapy- Proceed to question **3** ☐ ankylosing spondylitis (AS) - Proceed to question **4** ☐ non-radiographic axial spondyloarthritis with objective signs of inflammation (nr-AxSpA) - Proceed to question **4** ☐ psoriatic arthritis - Proceed to question **3** ☐ Other diagnosis or indication – **STOP Coverage not approved**	
3. 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 **5**	☐ No **STOP** **Coverage not approved**
4. 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 **5**	☐ No **STOP** **Coverage not approved**

5. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes Proceed to question **6**	☐ No Proceed to question **8**
6. Has the patient had an inadequate response to Humira?	☐ Yes Proceed to question **9**	☐ No Proceed to question **7**
7. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
8. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Stelara (ustekinumab)?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Cosentyx (secukinumab)?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. 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