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:**

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|---|---|---|
| **1. Is the patient 18 years of age or older?** | ☐ Yes<br>Proceed to question **2** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **2. Does the patient have moderate to severe plaque psoriasis?** | ☐ Yes<br>Proceed to question **3** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **3. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?** | ☐ Yes<br>Proceed to question **4** | ☐ No<br>Proceed to question **6** |
| **4. Has the patient had an inadequate response to Humira?** | ☐ Yes<br>Proceed to question **7** | ☐ No<br>Proceed to question **5** |
| **5. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?** | ☐ Yes<br>Proceed to question **7** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **6. Does the patient have a contraindication to Humira (adalimumab)?** | ☐ Yes<br>Proceed to question **7** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **7. Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Stelara (ustekinumab)?** | ☐ Yes<br>Proceed to question **8** | ☐ No<br>**STOP**<br>**Coverage not approved** |

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|---|---|---|
| **8. Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Cosentyx (secukinumab)?** | ☐ Yes<br>Proceed to question **9** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **9. Is the patient a candidate for systemic therapy or phototherapy?** | ☐ Yes<br>Proceed to question **10** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **10. 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<br>Proceed to question **11** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **11. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?** | ☐ Yes<br>Proceed to question **12** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **12. Will the patient be receiving any other targeted immunomodulatory biologics with bimekizumab, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rinvoq ER, Rituxan, Siliq, Simponi, Skyrizi, Stelara, Taltz, Tremfya or Xeljanz/Xeljanz XR?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**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